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LECTURE.[1]

FOODS FOR THE SICK.

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(Specially reported for the MEDICAL AND SURGICAL REPORTER.)

Milk is by far the most important food which we have to give to the sick, as it contains all the substances necessary for the support of the human body. No doubt many of the recipes which I shall speak of are well known; still those who attempt to follow them often fail from lack of attention to small details; so I would emphasize the importance of following the directions which I shall give implicitly, and especially of being sure to measure each ingredient used.

A doctor will rarely be called upon to make these articles; but it is of the greatest importance for him to know exactly how to direct the person in attendance to prepare the food, and when prepared to be able to tell that it is made as desired. Where there is only one sick person to be provided for, it is wise to prepare small quantities of any food at one time, and in serving to be sure to have the food either hot or cold, and never lukewarm. When prepared, the same food should be presented at different times in different dishes, and uneaten food should never be allowed to remain in the sight of the patient.

Barley water.—Barley water is best prepared by taking one ounce of barley and covering it with one quart of boiling water; it is then to be boiled rapidly five minutes, and the water thrown away, as it has an objectionable color. Add a first boiled water—by this I mean water which has just come to the boiling point, and not that which has been drawn from the hot water faucet, or that which has been boiling on the fire for hours at a time. A first boiled water is cold water which has been heated

[1] Delivered at the University of Pennsylvania, November 21, 1888, and provided through the liberality of Dr. George Strawbridge.

rapidly until it boils and has not parted with its gases. Let the pot in which the barley and water have been placed simmer, not boil, gently two hours, strain, and it is ready for use.

Two thirds of milk and one third of barley water prepared in the above manner, make a most acceptable food, especially in typhoid fever, where we desire some starchy food.

Koumiss.—For koumiss mixed milk is the best, Alderney milk being too rich. Put one quart of sweet milk into a farina boiler, and stir constantly (over the fire?) until it has reached blood heat. Dissolve one quarter of a cake of compressed yeast in two tablespoonfuls of lukewarm water; stir the yeast until it is thoroughly dissolved. If you are unable to procure compressed yeast, two tablespoonfuls of liquid yeast may be used. Take one ounce of sugar (which is equal to two tablespoonfuls of sugar level to the brim) and dissolve it in two tablespoonfuls of water; stir over the fire until it boils, and then allow it to boil ten seconds; when you should have a perfectly clear syrup. Put the yeast into the milk and then add the syrup, stirring backward and forward, until they are thoroughly mixed.

Fill a quart bottle up to the neck with the mixture, and put in a tight fitting cork, which must be fastened down by means of a string; and keep the bottle in an upright position at a temperature of 70° F. for twelve hours; then in a temperature of 55° F., the bottle being placed on its side. The koumiss is ready for use in twenty-four hours; but patients often prefer it after standing forty-eight hours, as the taste is then slightly more acid.

Scalded milk.—There is a great difference between scalded and boiled milk. If we place milk in a farina boiler, no matter how hard we may boil the water underneath, the milk in the upper kettle will only be raised to a temperature of about 204° F., and this is not enough to boil milk. Scalded milk is often much more acceptable to a patient and not nearly as constipating as ordinary boiled milk. Put a quart of milk in a farina boiler and as soon as a scum of coagulated albumen floats on the surface the milk is scalded. In boiling milk the caseine which sinks to the bottom is apt to be burnt. I have known patients, who would become disgusted with boiled milk in a few days, to relish milk prepared in this way for months at a time.

Carrageen.—Take two pieces of Irish moss, thoroughly cleaned from any adherent sand and dirt, add some cold water, and let them soak five minutes; then wash, and allow to soak five minutes more in cold water, when the moss will have a soft, white look, and, having absorbed water, will be considerably increased in size. Scald one half pint of milk, and, after shaking any adherent water from the moss, drop it into the farina boiler. Stir well, and then cook, with the lid on the pot, for five minutes. Add one ounce of sugar. No flavoring extract is to be added unless especially ordered; but vanilla, wine, etc., may be added, or a sauce may be made and added to the jelly when cold. Strain through a sieve, and put into small moulds, which have been washed with cold water so as to prevent the jelly from adhering to the sides; then it is taken from the moulds and placed immediately on ice, or in a very cool place, and it will be ready for use in about one hour. It must be served very cold, or it will have a fishy taste. The quicker it is made, the better it is.

Milk punch.—Milk punch is made by taking two thirds of a tumbler full of milk and one half-ounce of sugar, and adding the amount of spirits ordered. The whole must be thoroughly shaken, with or without ice, in a wide mouthed bottle or a tin shaker; and then served in a clean tumbler. A little nutmeg grated on the top, makes the flavor more acceptable to some palates.

Egg-nog.—Egg-nog may be prepared with the whole egg, or with the yolk, or the white of the egg alone. If the whole egg is to be used, separate the white from the yolk and beat the white until it is light—not to so dry a froth, that it would stand alone. Then beat the yolk, and slowly add one half-cup of milk to it; put in some ice—not cracked too fine; add the white of the egg and one half an ounce of sugar, and beat until well mixed. Then add whiskey or brandy in quantities required, mix again, and serve at once.

If the white alone be used, mix as if making milk punch, but add from one to one-half ounce sherry, as this removes the taste of the white of the egg better than brandy or whiskey. Shake the whole as for milk punch. If correctly made there will be but little froth, the whole being of a light consistency. If the yolk alone be used, beat the yolk and add the milk slowly, beating all the time. Then add the sugar, ice, and spirits; and shake well.

Milk gruel.—Scald one half-pint of milk; add six good-sized raisins; and

allow to stand five minutes. Take a tablespoonful of corn-starch and thoroughly mix with two tablespoonfuls of cold milk. Add this mixture to the scalded milk quickly, stirring backward and forward over the fire in a farina boiler, until it begins to thicken; then add one ounce of sugar, and let it cook one minute. Strain, and place in moulds in a cool place.

Beef-tea.—Great care must be used in the selecting of meat for beef-tea, and that part of the meat is to be used which contains the greatest amount of nourishment. The piece best adapted for this is the "sticking-piece" (that part of the neck where the knife is thrust through in killing the animal), as here there is the greatest amount of blood in the part. The worst piece is the tender-loin. If the sticking-piece cannot be obtained, take the round. It is indifferent whether you use the upper part, which is the tender part, or the under side.

Take one pound of meat which has been well freed from fat, and chop it as fine as possible; add one pint of *cold* water; stir well; and allow to stand in a cool place for two hours. The cold water is added to soften the fibres and extract the juices. If boiling water is added a film is coagulated on the outside, and no amount of boiling will make it tender or extract all the juices. Stir the beef-tea, as it is soaking, every little while. Put in a farina boiler; but do not let it boil. For seasoning, it is better to add six whole peppers than the ordinary ground pepper. A bay-leaf imparts an agreeable flavor, and may often be added with no harm to the patient. Salt is to be added just before taking from the fire, because if it be added sooner the fibres are hardened and the juices are prevented from coming out. The fat that rises to the surface is to be removed with small pieces of white blotting paper. Keep stirring till the red color is changed to a slight white tinge, which will occur in about fifteen minutes. Then cover the kettle for a few moments and strain, pressing hard to get all the juices out.

It is wise to prepare beef-tea fresh every day, and never to hurry its preparation. Beef-tea is to be served icy cold or very hot; and to prevent the tea from cooling in being carried from the fire to the sickroom, it is wise to serve it in a metal tea pot, pouring the beef-tea into a cup only when the room is reached. Never warm up more than you intend to use, and any quantity left over must not be poured back into the remainder of the tea. The fibrin settles to the bottom, therefore before re-warming, be sure that the vessel in which the beef-tea is kept, is well shaken When properly prepared, beef-tea should not have a cooked taste, like a soup, but should taste more like rare meat.

Clarified Beef-tea.—Take the shell of one egg and crush it in small pieces; add the white and a little water and beat until well mixed. Allow the beef-tea, prepared in the manner stated above, to come to a boil, and then add the shell and white of the egg. Allow the mixture to boil in a covered vessel for two minutes; and strain, and the dark colored beef-tea has given place to a clear light straw-colored liquid. This liquid is very stimulating and should not be given in more than two ounce doses at a time, or it may lead to dangerous symptoms from over stimulation.

Mutton Broth.—Mutton is less nutritious than beef, but is more easily digested, and can often be given when the latter should not be introduced into the system. The sticking-piece is the best part to use. Take one and one-half pounds of meat and one and one-half pints of water, and two tablespoonfuls of previously washed rice (if necessary the rice may be omitted) put on a slow fire, and allow to come to the boiling point; then remove any fat that may come to the surface, and allow to simmer for three hours. Keep the pan covered so as to prevent the evaporation of the water; strain; and re-warm as needed. Celery salt can often be added, and this imparts a nice flavor. The milky color is due to the rice.

Chicken Stock.—The legs and wing of the chicken make the best stock, as the sinews and bone in them contain gelatinous materials. The breast of the same fowl can often be saved and cooked for the patient in some other way. Take a one-pound chicken, which has been cut in large pieces and the bones cracked, and one pint of water, and allow it to soak three-quarters of an hour. Then simmer in a closed pot for two hours. Salt and pepper are then to be added, and the whole strained, and removed at once to a cold place. The fat is to be removed when cold, by a spoon. The solid stock as thus prepared can be used for food, or by adding water and heating, and afterward cooling, it may be served as a drink, or it may be given warm, in the form of soup, with or without rice.

Wine Whey.—The caseine can be removed from milk by acids, such as lemon juice, tamarind juice, wine, etc. Take one half-pint of milk; raise it just to the boiling point; add one-half as much sherry or madeira;

and remove it from the fire. Strain through a fine sieve or several thicknesses of cheese cloth. Do not squeeze, as all the curd must be removed—otherwise, it would be more indigestible than plain milk. Wine whey must not have too white a color, as this is a sign that the milk has boiled. Serve warm or cold, slightly seasoned.

Beef-tea with Yolk of an Egg.—Take one gill of clarified beef-tea, scalding hot, and thoroughly mix the yolk of an egg with a small amount of the liquid; pour quickly back into the pot; stir; and serve at once.

Cream Beef-tea.—One of the nicest and most nutritious dishes for the sick that I know of is prepared as follows: To one ounce of well made beef-tea, add an equal volume of barley-water; then heat, but do not boil the mixture. Add the whole to a half ounce of cream or to the yolk of one egg, stirring well. Heat for a minute, and serve at once.

Boiled Eggs.—To boil eggs so that they can be most easily digested, bring some water to the boiling point, drop the eggs in, and remove the vessel from the fire. Allow to stand five minutes, and when served the whites will be found cooked, but as soft as the yolk.

Scraped Beef.—Prepare two ounces of scraped beef by scraping a piece of beef in the direction of the fibres, and not across them. Put on a piece of bread one inch square, being sure that the meat is well pressed into the pores of the bread. Dust with salt, and toast both sides for a minute over a hot fire.

COMMUNICATIONS.

IDENTITY OF SCARLATINA AND DIPHTHERIA.

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A few years ago the medical journals were teeming with arguments for and against the identity of diphtheria and croup. While the argument in favor of this doctrine seemed inconclusive to me, I wondered at the silence of the profession on the present subject. And while I wondered and waited the arguments and evidence kept piling up till the conclusion was irresistible.

The fact that they have so long been considered two diseases is no reason why the truth of it should not be questioned. Error may exist for centuries and when it is detected it is hard for us to believe we could have been deceived so long. For example, Galen taught that the blood passed directly from the right side to the left side of the heart through the pits he observed between the columnæ carnæ, which pits he supposed were the openings of foramina. This idea no one dared deny and "it stood undisputed for a thousand years and three centuries more." How strange it seems to us now that such a glaring error could be undetected under the eye of the medical profession for those thirteen hundred years.

Diphtheria meaning "a skin or membrane" is named from its gross pathological lesion. *Scarlatina*—"a deep red," is named from its prominent symptom. But these names signify nothing, for we have diseases named from the progress they make, as *cancer* referring to the movements of an animal; or from the actions of a patient as *chorea*—"a dance," and so on with no rule for the names we use. This is wrong and no doubt in time will be so changed that from the name of a disease its pathological lesion may be known. But what's in a name? "A rose by any other name would smell as sweet."

Thus, with no rule to guide in the application of names, it is not strange that one disease should receive two or more names as different observers were impressed by different pathological lesions, or different conditions, or symptoms.

So with the two diseases under consideration; one is named as we have seen from its pathological lesion, the other from its prominent symptom; but this difference of name does not prove that the diseases are *two*.

If, on the other hand, it can be shown that they are alike in etiology, pathology, symptoms and sequelæ, and then cases cited where one disease is generated from exposure to the other, it must be conceded that their identity is highly probable.

This I shall attempt to do by a careful research of the literature of the subject, and by the report of a few cases from the records of a private country practice, where every facility is present for knowing the source of infection. And what we have to say as to pathology, cause, symptoms, or sequela, is substantiated by these works and again by the cases recorded.

As to *Pathology*.—Both are infectious. Both are but slightly contagious. Both are diseases of the glandular structure, affecting regularly the adenoid tissue; the adenitis being a part of the disease and not a complication. Both present a croupous inflammation of the mucous membrane of the

tonsils and pharynx, often extending to that of the stomach and bowels. And, according to Drs. Delafield and Prudden, "such a croupous inflammation in diphtheria is anatomically identical with croupous inflammation due to trauma and *other* causes."

Admitting then on their authority that the throat trouble is the same, it behooves us to show that the causes are the same. This we can not do, but far less can it be proved that they are different. And as to their etiology, we know nothing positive of their real cause, but judging from its effects and mode of behavior, it is generally conceded to be a micro-organism. The micro-organism of these diseases has not yet been subjected to the crucial tests of always finding it present in the lesion, of isolating it by a series of pure cultures, and, lastly, of reproducing the disease by inoculation with these isolated cultures. Prof. Palmer says: "The specific character of diphtheria, its dependence on a poison, cannot be doubted. But the positive character of that poison has not been demonstrated, and its mode of action in producing such serious results is unknown." The same may be said of scarlatina. While acknowledging the want of knowledge as to the exact germ, we must all have been impressed by the similarity of its workings in the two diseases.

In both it acts best. or the susceptibility is greatest, between the ages of two and seven years. In both the period of incubation varies from a few hours to seven or eight days, with an average of four days. In both the micro-organism clings to life with great tenacity, each disease having been contracted by persons occupying rooms where many months before there had been patients affected by one or the other disease. In both it is often impossible to trace the source of infection. Hence we say both are sporadic, if not spontaneous. In both the contagium not only is carried directly from the sick to the well, but it may also be communicated through a third party, or through fomites in which it may lie dormant but preserve its vitality. Both attack and complicate wounds. In both one attack produces immunity against future attacks as a rule, while recurrent attacks in either are not very infrequent.

In symptoms both vary from the mildest to the most malignant type. Both have a common seat of croupous inflammation, namely, the mucous membrane of the fauces and nasal passages. Both agree in the profound toxæmia and prostration in graver cases. In both there is an eruption.

In *sequelæ* they agree by both having the adenitis and nephritis, which are considered as a regular part of the disease, but which some consider as complications. J. Solis Cohen calls especial attention to the physical resemblance between the pseudo-membranous casts in diphtheria and the desquamated epidermis of scarlatina. In both we have paralysis of the muscles of the throat.

Now, having shown these striking similarities as conceded by the authors quoted above, I present a few cases in which most of the points of identity are illustrated. I well know I am likely to meet the thought, whether expressed or not, that I have been mistaken in my diagnosis, and that the cases I called diphtheria were simply scarlatina without the eruption.

While I claim to have ordinary observing powers, and to be capable of making a differential diagnosis, as it is generally called, I must fortify my position by stating that every case but one was seen by one or two other good practitioners of many years' standing, practitioners whose opinions stand unquestioned where they are known.

Case I.—Myrtle H.—After complaining a few hours the patient was seized with a general convulsion. I saw her in half an hour and found her in a state of great prostration, with the twitching of muscles and the rolling of the eye-balls so characteristic of approaching convulsions. Her temperature was 104°, which steadily increased to 106½° just before death, which occurred in twenty-four hours from the time of first convulsion. When she was first seen there was a croupous membrane on both the tonsils and on the posterior wall of pharynx. At this time considerable swelling of the glands of the neck was present, which steadily increased. An eruption was to be seen, dim but sufficiently distinct, when taken with the other symptoms, to warrant a diagnosis of scarlatina, a diagnosis which was confirmed by Dr. Clarke, who saw her shortly before her death.

No history of contagion nor of infection could be obtained; her two brothers and her sister did not take the disease, though they were in the room during her sickness.

No other case occurred for 10 days, when I was called to see

Case II, Bert W., 12 years old, who lived three miles from the first patient. I saw the patient on the second day of his sickness, and was informed that a diagnosis of diphtheria had been made the day before by another physician. The throat did look

like it, but a further examination revealed a typical scarlatinal eruption on the body and limbs. The case ran a favorable course, ending in profuse desquamation followed by general œdema. The only source of infection was association with the man who held Case I in his arms while the patient was in her first convulsion, ten days before.

Case III.—In five days after Bert was attacked, Worden K., who was living in the family with Bert, was stricken down and had a typical case of scarlet fever.

Case IV.—Mrs W., the mother of Bert, in a week from the beginning of the latter's sickness was attacked by fever and sore throat, with a deposit on both tonsils and pharynx, and every symptom to make a case of diphtheria. No eruption was present at any time.

Case V.—Clint W., the brother of Bert, in two weeks after the latter's illness was attacked by chill, vomiting, fever, and all premonitory symptoms of scarlatina, which subsequently developed.

Case VI.—Lanie W. was a playmate of Bert whom Lanie had visited a week before he was attacked, and while Bert was in the midst of his fever. When first seen he had a temperature of 102½°, and a typical diphtheritic deposit in the throat. No eruption was then to be seen, nor did any appear afterward. He was said to have had scarlatina nine years before.

Case VII.—In five days after Lanie was taken sick his sister, Bessie W., was taken with a chill, and in eighteen hours was thoroughly covered with a scarlatinous eruption, with a diffuse mottled redness of the throat, but no deposit. In due time desquamation came on and the muscles of the throat were partly paralyzed for several months, to such a degree that she swallowed with difficulty, and articulation was at first impossible. Both gradually improved.

Case VIII.—Charles R., a neighbor to W.'s family, where Bert, Clint, and others lived, did not himself come in contact with the sick, but from the beginning of sickness in this family his wife visited them often. In eight days from the beginning of Bert's attack this patient was stricken down with what I pronounced diphtheria, a diagnosis confirmed by Dr. Clarke.

The next group of patients was three miles distant from the first group just reported, and had no communication with them whatever.

Case I.—While visiting Myrtle (Case I of the first group) a messenger came hurriedly saying that his child had croup. I had seen the patient, Opal W., two days before, at which time she had a temperature of 100°, with a slight deposit confined to the tonsils. At that time she had a dull, listless expression, which I was informed had existed for a week. Knowing this much about the case I at once concluded the croup was due to extension downward of the false membrane I had seen two days before. Upon visiting her I found her very hoarse, with a pseudomembrane covering both tonsils, the pharynx, and extending high up on the soft palate and as low down as I could see. I at once made a diagnosis of diphtheria, with a fatal prognosis. Dr. Franks saw her with me in the evening of the same day, and confirmed the diagnosis. At this evening visit the hoarseness was nearly gone, but in no other respect was she better. Next morning her temperature was 104°, and she was fast sinking. Diarrhœa had set in during the night. Fluids regurgitated through the nostrils when she attempted to swallow, showing paralysis of the muscles of the throat.

The source of infection in this case could not be found, but may be conjectured as follows: The patient and Myrtle—the first patient of the first group—had been taken to a large funeral three weeks before. As both were attacked about the same time, and as this had been the only place at which either had been from home, it seems probable that both were infected at this funeral, though one died of scarlatina and the other of diphtheria.

Case II.—Five days after Opal died her brother, Claude, was seen with a characteristic diphtheritic deposit in the throat, and all the symptoms which go to make up a case of diphtheria. No eruption appeared and he made a good recovery.

Case III.—The night before Opal died, Mrs. C. attended her, holding her in her lap. Without changing her clothes she went home among her own children. In a week Ed. C. was attacked. In twenty-four hours he was thoroughly covered with the eruption of scarlet fever, which ran a severe course, but ended in recovery after an abscess had formed on each side of the neck.

Case IV.—A week after Ed. was attacked his sister Alma was attacked with a sore throat which looked like that of diphtheria; no eruption was ever seen.

In another family consisting of father, mother, and five children, the five children had well-marked scarlet fever, while the mother had as severe and as well-marked an

attack of diphtheria as I ever saw recovered from. The false membrane covered the tonsils and pharynx and extended up over the soft palate and out on the hard palate to near the incisor teeth. She was exposed to no infection except from her children with scarlet fever.

This family had no communication with either group of patients reported above.

In addition to my own cases, I offer a few from Dr. Mendenhall, of Woodford Co, Ill. He says: "A young man who had been West came home sick. I saw him the day after his arrival and found him suffering with diphtheria. He had been boarding in a family in which one child had died of this disease. This young man recovered, and his sister, two years younger, was then attacked with diphtheria and had a very hard struggle with the disease. Before she recovered her two younger sisters, five and seven years old respectively, were attacked with scarlatina, the younger one dying. There had been neither scarlatina nor diphtheria in the neighborhood up to that time. Immediately afterward I treated in that neighborhood four cases of scarlatina and nine of diphtheria. The original case was one of diphtheria, and the first two patients with scarlatina were in the house with it. Undoubtedly the scarlatina was developed from contagion of diphtheria."

Dr. J. B. Clarke, of Economy, Ind., to whom I referred as seeing some of my patients, writes: "I am quite willing to be quoted as confirming your diagnosis in the cases to which you refer. I have observed for many years the close relation between diphtheria and scarlatina, and believe them to be identical. A number of times when scarlatina was prevailing epidemically, I have had in the same family well-marked cases of scarlatina and of diphtheria. I have never known an epidemic of scarlatina without quite a good deal of diphtheria in the same locality. I have no doubt of the identity of the two diseases."

In the transactions of the Chicago Medical Society, Nov. 16, 1885, I find the following: Dr. Carter mentions the fact that simple cases of tonsillitis are often accompanied or followed by diphtheria or scarlatina among other members of the same family. Dr. Quine says: "Often one member of a family, probably the first one attacked, exhibits plainly-marked features of simple follicular tonsillitis, and those who sicken afterward exhibit the phenomena of diphtheria or, less frequently, those of scarlatina."

Dr. Stevenson relates a case in which a child took scarlatina from its mother who had tonsillitis. The child died and the Doctor says: "This is the first case in which I ever suspected that a benign form of tonsillitis might reproduce a malignant form."

Dr. Angear, at the same meeting, comes nearer advocating the doctrine of identity when he says: "We can readily imagine a robust, healthy child, with strong resistance to morbid influences, and especially that of diphtheria, on exposure would have simple tonsillitis; but suppose his brother, with strong susceptibility, is exposed to the same morbid influence; he will develop a case of undoubted diphtheria.

"In this house we have tonsillitis and our neighbor severe diphtheria. By remembering these facts, we shall see that it is, or may be, all the same morbid influence here and yonder—here, recovery in a few days; there, death in a few hours."

I have shown by the case of Bert that scarlatina may be conveyed by a third party from one with scarlatina; and by Charles R. that diphtheria was carried from scarlatina; and by Ed. C., that scarlatina may be carried from diphtheria.

From Bert, who had scarlatina, two cases of scarlatina and three of diphtheria developed; from Lanie, with diphtheria, his sister contracted scarlatina; from Opal, with diphtheria, her brother contracted diphtheria, and Ed. C., scarlatina; from Ed., his sister contracted diphtheria. Opal, with diphtheria, had paralysis of the muscles of the throat, which also occurred in the case of Bessie, sick with scarlatina.

Let me insist that when I say diphtheria I mean this dreaded disease, and not every affection of the throat in which there is an exudation; and that I rule out all cases of simple and follicular tonsillitis, which are so often classed as diphtheria by a class of practitioners who desire the reputation of curing all cases of diphtheria. Another thing I wish to emphasize is the inability to trace the source of infection in city patients, and the reliability of an investigation of this matter by a country practitioner. For parents in the country can tell every place to which the child has been for six months, and also who has been at the house, and almost everyone who has been within a mile of the patient for the same length of time.

Knowing this and having my diagnoses confirmed by such reputable physicians, and my ideas corroborated by such careful country practitioners as I have mentioned, and the, to me, unanswerable argument

presented by the cases recorded, I am forced to the conclusion that scarlatina and diphtheria are very, very similar, if not identical.

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TYPHOID FEVER.

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Since Feb. 4, 1888—the date of my short article on typhoid fever in the REPORTER—I have witnessed a remarkable endemic of typhoid fever, in Polk County, Tennessee. In seeing, diagnosticating, and treating fevers for more than forty years, I never met with so puzzling a group of symptoms before in my practice.

The fever district was about six miles long, by three wide—lying between the Hiwassee River (a tributary of the Tennessee) and Chilhowee Mountain, a part of the Allegheny range. This section of country is mainly level or slightly undulating, and interspersed with basins of water in wet seasons, like the latter part of the past summer and fall. The soil is poor and sandy, and is mainly drained by three small streams which take their rise at the base of the mountains, running a little south of west across the fever-stricken section, and emptying into the Hiwassee River. The streams are quite subject to overflow, spreading over a considerable amount of low lands, depositing a quantity of filth and mixed soils, in various portions of this particular section of country; in wet seasons this part of the country is mainly cultivated in cotton by renters, some of whom are colored people, nearly all of them living in old, dilapidated log-houses, with a great many small outhouses, in a filthy condition. Near the river there are some large, well-ventilated, and comfortable dwellings; in which also the fever prevailed to a considerable extent. The water supply comes mostly from shallow wells, not in the best condition.

The disease was confined to persons in the prime of life—none, I believe, under ten, or over thirty or thirty-five years of age. The onset of the disease was invariably slow, insidious, and tedious; the patients moped around for some days, or even weeks, before being confined to their beds, complaining of nothing but weakness, and indisposed to mental or physical exertion. One of the first symptoms worthy of note after the patients were confined to bed, was sick stomach and vomiting of bilious matter. This latter symptom, in some cases, was quite troublesome and intractable—fully as much so as in bilious remitting fever—and was accompanied with a bilious diarrhœa. The morning remissions were pretty well defined, and seemed to be controlled by the use of quinine; but this drug had little or no influence upon the regular course of the disease. The coat on the tongue would peel off, and again reappear, as in typical cases of typhoid fever. The tongue was not so pointed, nor its edges and tip so clean and red as is usual in typhoid fever. The pulse was quick and small, with a well-marked reacting beat, even when the patient was perspiring well from the use of quinine. It would range from 90 to 100 beats in a minute in mild cases, and from 100 to 120 in grave cases.

The range of temperature in all cases that came under my observation, was in proportion to the gravity of the case. The duration of the disease was from four to ten weeks in cases of recovery; and the fatal cases were from three to five weeks in duration.

Abdominal symptoms.—A tympanitic state of the bowels was not common, in the cases I saw; the bowels seemed flat, and rather hard, very sore on pressure, and especially if pressure was made over the right iliac region. The bowels had to be controlled throughout the entire course of the disease; the color of the evacuations was yellow, and dark, and they had a strong bilious odor. Epistaxis and hemorrhage from the bowels were seen in many cases. The latter symptom was probably induced in some of the cases by the use of too frequent, or strong purgatives, as there were several physicians in the fever-stricken district entertaining very different views of diagnosis and treatment.

The disease was diagnosticated, by the various practitioners who saw it, to be nearly every kind of fever known to the medical profession. I think most practitioners, seeing one of these cases early in its onset, would have been inclined to call the disease grave bilious remittent fever, and more especially if they ignored, or paid little or no attention to, the tediousness of the onset. The impression made upon my mind, in seeing the first case, was that I had a grave case of bilious remittent fever to contend with, strongly marked with a *typhoid type:* and I remained twenty-four hours with the patient watching the action of medicine, and left undecided as to the real nature of the case, and impatiently waited the further developing of symptoms.

On my next visit I saw plainly I had a case of typhoid fever in a person with a malarial diathesis—what some practitioners call "*typho-malarial fever.*"

I stated in an article on typhoid fever, published in the *Augusta Medical and Surgical Journal*, about the year 1854 or 1855, when the late lamented Dr. Eve was its Editor, that where typhoid fever prevailed, malarial fevers were uncommon, and *vice versâ;* and I have had no cause to change my opinion until the present endemic occurred. This is the first time I ever witnessed a typhoid fever endemic or epidemic, or even sporadic cases in a district in which malarial fevers were prevalent. Others I have no doubt have a different experience; especially in malarial districts of old settled countries. There can be little doubt that the poisons of malarial and typhoid fevers are as essentially different as are the poisons of small-pox and typhoid fever, or of any one of the specific diseases. I have examined as faithfully as I could, with the limited means at my command, into the cause or causes of typhoid fever; and in this section of country have certainly traced them to *filth;* such as is found in old, damp cellars, filthy drinking-water, cesspools, old filthy out-houses, and accumulated about old farm-houses and out-buildings. I could illustrate these facts by the recital of many cases. I think the facts are as well established as that so-called malaria produces periodical fevers. It is well known by all observing medical practitioners who have many years' experience, that the home of periodical fevers is in newly settled countries; and that of typhoid fever is in old settled places. This view of the subject does not limit malarial fevers to new settled districts or typhoid fever to old settled ones; but as a rule what I have stated is the case.

The belief that different kinds of microbes in malarial and typhoid fevers, develope different groups of symptoms and require altogether different medicines, as germicides, seems to have brought us no nearer to successful treatment in either form of fever; nor do I think it ever will. While I am willing to admit the fact, of the finding of different kinds of micro-organisms in the various diseases of the human body, I cannot believe that they are the cause of disease, but look upon them rather as its *product.*

My reason for diagnosticating the fever of this endemic as typhoid is this: that the remarkable group of symptoms which makes up the picture of typhoid fever was clearly seen throughout its entire course. Notwithstanding the sick stomach, the vomiting of bile, the bilious stools, the absence of tympanites in many cases, the fact that the tongue was not very characteristic, and that there were pretty well defined morning remissions in the fever apparently yielding to quinine, obscured the diagnosis. We had the tedious and insidious onset, bleeding from the bowels, epistaxis, constant diarrhœa throughout the entire course, soreness of the bowels, especially over the right iliac region, attended with a gurgling sound on pressure, a quick nervous reacting pulse, even when sweating was free; and the length of time in running its course even in those cases that progressed to a favorable termination. The muttering delirium so characteristic of typhoid fever was not well marked; the mind as a rule was clearer but slow and dull. This feature was so striking that I made it a practice to inquire after the natural turn of mind, and speech, when the patient was well.

I have said nothing about the *rose spots*, because I saw none of the patients before the end of the third week, and I found only what I took to be a faded eruption, but was not positive as to its existence.

I have but little to say on the subject of treatment, as I saw no patients but such as were far advanced in the disease—one of them, a negro girl, died from hemorrhage of the bowels. I saw one patient, who had been sick for seven weeks; who had had but little attention or treatment; she was treated in a mild conservative way with a proper course of diet, and stimulants, and she got up at the end of ten weeks. Others that I saw were slowly convalescing. I saw the last patient about November 30. I failed to meet the family physician, and, as the patient was doing well enough, I only advised following the directions given by his regular medical attendant, and that the patient should not be in too great a hurry about leaving his bed.

The fact that these attacks have extended into the winter months is confirmatory of the diagnosis of typhoid fever.

Finally, I would like to say that it seems to me we ought to have more help from our fellow-practitioners in regard to the matter of fevers, and less on gynecology. I cannot see why a practitioner is not entitled to as much credit for diagnosticating, and successfully treating a grave case of fever of any kind, as if he had performed a successful laparotomy.

JABORANDI.

BY J. B. CARRELL, M.D.,
HATBORO, PA.

In conversation with physicians, I find that the great value of this drug in the cure of disease is not fully appreciated, and for this reason I wish to speak of it.

The plant is found in Brazil, and its botanical name is *Pilocarpus pennatifolius*. The only alkaloid of value so far found in it is pilocarpine; others have been found, but they are of little use to the therapeutist.

As an introduction I shall state that the more the drug is employed the better it will be liked; at least such is my experience. The class of diseases in which it should be used is of the active or sthenic type, such as congestion of the lungs, pleura, and of other organs, in which are found great dryness of the skin and a high grade of fever. Its value in the early stages of high inflammatory conditions is very marked, and justly deserves a place in every physician's list of medicines. If an infusion of from sixty to ninety grains of jaborandi, or an equivalent of its active alkaloid, pilocarpine, be given to an adult, profuse perspiration will be produced in from thirty minutes to an hour, and will continue for several hours. The salivary glands will act quite freely, and if the saliva is swallowed, nausea and vomiting will in all probability be produced. This nausea, according to the observations of some, seems to be due to the irritating character of the saliva coming in contact with the stomach. Dr. Bruen, of Philadelphia, asserts that the dialysate of pilocarpine will not produce sickness of the stomach. The pulse and respiration are usually quickened and the temperature for a time may be slightly increased, but will soon begin to fall; at least it has done so in my experience. After the sweating has ceased, the patient is more or less exhausted, and should on no account be allowed to leave the bed unless he is well covered, in order to prevent chill and the syncope which may result therefrom.

The nasal and lachrymal secretions are very generally increased, and Gubler has noted diarrhœa. Ringer and other experimenters have not found this present. There is sometimes contraction of the pupils and even disturbance of vision. Ringer found children very insusceptible, but such has not been my experience either in children or in adults; the dose is not always constant, that is, free diaphoresis may be produced in one person with ten drops of the fluid extract given every hour, for three or four hours, while in another double this amount may be required, or even quadruple to produce the same effect. The sweat produced by jaborandi is often enormous in quantity. In cases of nephritis the loss by weight after injections of pilocarpine, according to Dr. Zelentski, of St. Petersburg, was 514 grammes or more than one pound; 306 grammes were lost by perspiration and 208 by salivation. The elimination of urea is said to be especially marked. For this reason the drug is valuable especially in destructive kidney diseases. The cause of the excessive secretion is a direct action upon either the gland-cells or the peripheral nerve endings, more probably the former. On account of its certain and powerful action as a diaphoretic it has taken rank as the most reliable remedy of its class, and has greatly extended the use of diaphoretics. It will be well now to take up its use in the various diseases.

In the early stages of pneumonia, that is, in the congestive stage—characterized by sudden rise of temperature, throbbing pulse, dryness of the skin, hurried and difficult respiration, chilliness, etc.—where my esteemed friend, Dr. Hiram Corson, would employ the lance and cold pack, I will, with equal confidence, put my patient to bed and produce free diaphoresis by the administration of jaborandi. With the appearance of free sweating there will be an amelioration of all the violent symptoms and a speedy and perfect cure within three or four days. A temperature of 105° in congestion of the lungs has, time and time again in my practice, been reduced to 99.5° in twenty-four hours.

While my friend, Dr. Corson, applies the lance to relieve the active congestion, I can produce as decided an effect with the drug under consideration. What has been said of congestion of the lungs can be said also of pleurisy. I am not writing from fancy but from experience.

Dr. J. M. Da Costa says that the pilocarpine treatment of erysipelas grows upon him, and, in thus speaking, my own views are expressed. It may be well to narrate one or two cases described by this eminent physician: "In a case of erysipelas of the face and leg the patient was given one-sixth of a grain of pilocarpine by hypodermic injection; two hours later he was given one-eighth of a grain and was purged with a mercurial pill. He was then ordered

twenty drops of the fluid extract of jaborandi every two hours, when he *did* sweat, and the disease was checked in twelve hours after the first hypodermic; the temperature went down to normal and he made a rapid convalescence from that time. He is now taking twenty drops of the fluid extract thrice daily; he still sweats, and his urine has increased from two and one-half to three and one-half pints in the twenty-four hours. The drug did not have sialogogue effects, nor did it seem to have any action on the heart. The second case is one of erysipelas of the nose. On admission the temperature was 103.5°. After the injection of pilocarpine it fell to 100°, later to 99°, and has never since been up to the fever temperature."

A week ago I was called to see a young man with erysipelas of the hand and arm, which were much swollen and very hot and painful. The temperature was 104°, pulse 120, with chilliness and general febrile symptoms. I gave him twenty drops of fluid extract of jaborandi every hour and a half alternately with three drops of tincture of aconite and one-half drop of extract of ipecac. In twenty-four hours the temperature had fallen to 99.5°, and all the unpleasant symptoms had disappeared. Locally warm flaxseed poultices and laudanum were applied. The treatment was completed by giving five drops of tincture of iron and two drops of Fowler's solution three times daily. I could mention many similar cases, but they would make needless repetition. If there is a tendency to exhaustion it is well to combine nux vomica and digitalis as heart tonics. By this course exhaustion will be obviated and the good effects of the drug secured.

Jaborandi has been largely employed for the relief of dropsies, especially the dropsies resulting from the destruction of kidney substance. In uræmic poisoning it is the most efficient remedy at our command. It is certainly of great value in either acute or chronic Bright's disease. The œdematous collections formed in this disease can be relieved by the use of jaborandi. It is asserted confidently by some that it acts in a special manner upon the kidneys, helping to free the tubes when they are obstructed with epithelial or fibrous *débris*. In the acute cases, in conjunction with proper diet, it may bring about a cure. The word "cure," says a writer, should be used in this connection in the same sense in which we apply the word cure to any other disease in which organic changes have taken place; or, in other words, the cure would consist in assisting nature to stop a morbid process by throwing off effete material, and by placing a barrier between diseased and healthy structure. The principle upon which we base our action is the benefit to be derived from *rest* in the relief and cure of inflammations. By the use of jaborandi the skin performs double duty—its own work and also that of its co-laborer, the kidneys. The latter are rested and inflammatory action is suspended. Wherever and whenever we can, we should place inflamed tissue at rest. That which cannot be cured with medication may without medicine be cured by rest.

In scarlatina, jaborandi is a most valuable remedy. It can do valiant service. Its well-known action upon the skin makes it of especial use in all of the exanthematous diseases. I have used it in a great many cases of scarlatina with the happiest results, and cannot help thinking that many cases of nephritis might be obviated by its use.

Little has been said of the value of jaborandi as a galactagogue. The mammary glands in many respects resemble the action of sudoriferous glands, and in cases in which the milk supply has failed, or is failing, it can be increased and redeveloped by the administration of jaborandi. This has been conclusively proved by numerous experiments. To obtain the galactagogue effect jaborandi should not be given in sufficient doses to effect free diaphoresis. In case of scanty supply, daily doses are required for ten or twelve days. If there is complete cessation of the milk secretion, it will be necessary to administer the drug every three or four hours, until gentle diaphoresis is established, and then keep up daily doses until the secretion is fully established. The patient, as is usually the case, will be run down, and should be built up with tonics and a generous diet. On January 5, 1885, I delivered a multipara of a fine boy baby. I saw her on the 6th, 7th, and 9th. At the last date the milk secretion was established and the temperature was normal. On the 11th, I was summoned and found her temperature 105°, pulse 130, severe headache, chilliness, coated tongue, dry burning skin; secretion of milk stopped, and breasts extremely sensitive and inflamed. The symptoms were as bad as one could wish if a test were needed for a drug-trial. I ordered free doses of jaborandi every two hours until free sweating had taken place. In three or four hours the dry hot skin was moist and in six hours she was in a dripping sweat. Small doses of quinine were given

every four hours and also five drop doses of extract of jaborandi. Twenty-four hours after the first dose of jaborandi the temperature had fallen to 99.5°, the milk was re-established and every unfavorable symptom had become favorable. This is one of several cases I have treated in this manner, and the result has been highly satisfactory.

The action of pilocarpine and atropine are directly antagonistic, so that in cases of belladonna poisoning jaborandi should be employed as the physiological antidote I have not had the opportunity of testing their antidotal effects, but others have had, and in the cases I have seen reported the results have been favorable.

Dr. H. C. Yarrow, of Washington, D. C., has been recently experimenting with the view of determining the value of certain reputed antidotes to serpent venom. All of them in his hands have thus far proved useless with the exception of the fluid extract of jaborandi, which seems to possess antidotal powers—at least in the case of mammals; but upon fowls it appears to have no such effect. He has given hypodermically to rabbits fourfold lethal doses of crotalus venom, and then by the administration of thirty-five drops of the fluid extract of jaborandi he has prevented any serious results. Dr. Josso, of Paris, reports a case of viper bite cured with an infusion of jaborandi leaves.

While much more could be written on the subject, I think what I have already said will awaken an interest in this very valuable drug, and am sure that its powers and uses will be appreciated if they are fully tested.

—Dr. Ira Russell, of Winchendon, Mass., died December 19, of pneumonia, at the age of 74 years. He was graduated from the Medical Department of the New York University in 1844.

—The Tennessee *State Board of Health Bulletin* for November, says: The number of localities reporting the existence of typhoid fever each month in Tennessee demands of the local health authorities immediate and careful investigation. No water or soil contamination, no typhoid fever, is the axiomatic teaching of sanitary science, and consequently no weary weeks of suffering and prostration, no long nights of anxious watching by friends, and no untimely deaths, whereas hundreds are now annually consigned to premature graves by this preventable scourge.

ODD COURSE OF A MISSILE.

BY E. H. PARKER, M.D.,
POUGHKEEPSIE, N. Y.

Very few persons practise surgery many years without meeting with instances in which missiles, such as bullets, pieces of shells and so on, take curious and often inexplicable courses after striking the bodies of living animals. In the following instance I was as much surprised as in any case with which I have met. In preparing for a frolic, a young man made a cannon by taking the long axle-box from the worn-out wheel of a horse-rake, plugging one end thoroughly, and boring a touch-hole. After loading this cannon, he fired it, and it being made of cast iron, and only one-fourth of an inch thick, it naturally blew to pieces. One of the fragments struck him. When I was called to see him, some thirteen hours later, it was evident that the missile was just underneath the skin of his neck, its upper end just touching the left mastoid process, and the only "solution of continuity" to be found was over the sternum, three-fourths of an inch below the upper end of that bone, and extending a little to the left of the median line. This wound was parallel to the upper margin of the sternum, was three-fourths of an inch long, and one-sixteenth of an inch wide. There was no discoloration of the skin at any point except that of entrance, which was a little bloody.

Making my preparations to meet any possible injury to the blood-vessels of the neck, I cut down upon, and removed, the fragment. Some bits of clothing were found just above the missile. There was no bleeding, and the patient recovered entirely in a few days.

The piece of iron weighs nearly two ounces (twenty-one grains short), is three inches long, one-fourth of an inch thick, and from three-fourths to seven-eighths of an inch on its convex surface for half its length, and then tapers to three-eighths of an inch. The other end, which was against the mastoid process, is broken almost square off, and is three-fourths of an inch across. All the edges of the fracture-lines are sharp and cutting. The convex surface of the fragment was next the skin. It has always puzzled me to understand how this piece of iron got through the small wound over the sternum, and from that point to the mastoid process, without breaking the clavicle and without doing any serious damage.

SOCIETY REPORTS.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, December 24, 1888.

The President, ALEXANDER S. HUNTER, M.D., in the chair.

DR. RALPH L. PARSONS read the history of

A Case of Cerebral Syphilis,

more for the purpose, he said, of emphasizing the importance of early and long-continued anti-syphilitic treatment than because of special interest in the case itself. The man, forty-five years old, of good constitution, married, came under his care with symptoms of loss of appetite, sleeplessness, depressed physical and mental condition, worry about business affairs, and fear of softening of the brain. His friends attributed his condition to worry over the sickness of his children. He began to have attacks of impending fainting, during which his ideas became confused, and he had difficulty of expressing his ideas. Before the attacks he was irritable. In spite of anti-syphilitic treatment, under which he improved for a time, he became worse, had attacks first of *petit mal*, later of *grand mal*, and finally died of symptoms due to syphilis of the brain. There had been no history of impure connection. But before Dr. Parsons saw him there had been a suspicious intractable ulcer of the lip. There was also evidence of syphilis, in sores on the scalp and in an eruption on the arm. It seemed probable that the cerebral symptoms might have been averted by early and long continued treatment.

DR. NATHAN S. ROBERTS read a paper on the

Treatment of Diseases of the Nose by the General Practitioner,

in which he called attention to some of the more common affections of the nose which when neglected were of great local annoyance, and frequently gave rise to reflex conditions which could only be cured by treatment directed to the nose. Among these reflex conditions which have been well established by both European and American authorities are: asthma, hay fever, vertigo, headache, disturbances of vision and of hearing. It is not necessary that the general practitioner should devote as much time to special training as is required of the rhinologist in the treatment of nasal affections; but with a moderate amount of clinical experience at the dispensary or medical school he will readily learn to do minor operations, to use the nasal speculum and mirror, to make applications of astringents and caustics if necessary, and to resort to those cleansing measures which are of so marked benefit in catarrhal affections. Speaking of chronic nasal catarrh, he said it is not only liable to invade the Eustachian tube, but to extend and involve the larynx and pharynx. The constant flow from the nasal passages into the stomach is a source of much disturbance to that organ. If the same care and discrimination were bestowed on these cases as are commonly given, for instance, to uterine diseases, the result would be at least equally successful. The author dwelt somewhat on the liability to loss of smell and its attendant dangers from long continued nasal disease, and sometimes from wrong treatment, such as the use of too strong astringents, or of mild ones too long continued.

DR. EGBERT H. GRANDIN then read the principal paper of the evening, entitled

A Plea for the Active Treatment of Puerperal Endometritis by Means of the Curette.

The profession, he said, accepts novelties in many other branches of medicine with much less conservatism than in obstetrics. While it is desirable not to manifest undue haste in the acceptance of new things, lest it appear like meddlesome midwifery, yet the author thought we should not reject good things because they had not been practised by our forefathers. Every day adds to the knowledge of the obstetrician who carefully watches his cases, and sooner or later facts show him that his early training in some respects has been faulty, and he may attain to that stage when he will admit that judicious meddlesomeness is good.

After delivery, the interior of the womb resembles a large surgical wound, except that the condition is physiological and not the result of disease. During a physiological puerperium the vast degenerative and regenerative changes going on in the womb and genital tract take place without disturbance of health; but if the normal process is arrested the fatty metamorphosis becomes checked or is replaced by necrosis; the cellular elements, the thrombi, etc., take on so-called puerperal degeneration. This process may start from any point in the endometrium, but usually from the placental site, and it extends progressively until it involves the whole surface. The surface,

often extending down to the muscularis, becomes converted into a mass of pus cells and a vast cicatrix. A part of the degenerative material becomes absorbed into the circulatory fluid, and gives rise to constitutional symptoms. If the surgeon found such a condition after amputation of a limb he would get rid of the slough as soon as possible. He would not rest satisfied with simply washing the wound and sprinkling on iodoform. He would remove decaying matter with the forceps and seek to establish healthy granulations.

The theory of to-day is that puerperal endometritis or septicæmia is a septic process arising from the introduction of germs into the genital tract. Without stopping to inquire whether this theory is well established, Dr. Grandin said it served his purpose to state that in the vast majority of instances the septic process is localized at the outset. The cases which constitute exceptions are those to which the French have applied the term *septicæmie foudroyante.*

The necessity for attacking the septic process while it is local, and before the poison has thoroughly invaded the general system, becomes evident to all. The symptomatology gives a very early clew to puerperal endometritis, yet the obstetrician requires the use of all his senses. Before the pulse, or the general aspect of the patient or of the lochia indicates danger, the physician will frequently find reason for suspicion in the odor imparted to his finger on examination of the cervix.

Prophylactic measures are of the greatest importance. As far as possible, asepsis should be observed during the lying-in period. Dr. Grandin does not approve of the routine use of the intra-uterine douche after delivery. If the accoucheur has reason to believe a part of the placenta or membranes is left behind, he should remove it, otherwise there will be great risk of puerperal endometritis. If it is good practice to keep out germs, it is better practice to leave nothing in the uterus which will prove a fertile soil for their development. If, however, endometritis has developed, what shall we do?

The practice of to-day seems to be to use the intra-uterine douche. As a rule, the fluid now employed is a solution of bichloride of mercury in water, and the douching is repeated once in three hours by some, by others as often as once in two hours or every hour, and it is continued sometimes a full week. The object of the douche is to stop the septic process. There are objections to this method. That the douche is not always effectual, but that eventually an adjuvant has to be resorted to, is the experience of all. The difficulty, if not the impossibility, of douching decomposing shreds out of the uterus has been demonstrated by experiments in washing shreds out of a bag. Then the danger of the toxic effect, even of death, from the agent commonly employed has to be considered. In certain maternities in Europe this danger is thoroughly recognized, and the use of a solution of corrosive sublimate is prohibited. Dr. Grandin had not used it in the intra-uterine douche for two years. There is the further objection to this mode of treatment, that it is often repeated and causes disturbance of the patient. There is also some danger of re-introducing septic matter, when the injections are continued at intervals for days.

It is the author's belief that we possess in the dull curette an instrument which will often replace the douche and at the same time answer all the indications. The indications are: to remove from the uterus the products of decomposition, whether free in the cavity, partly adherent, limited to the superficies, or extending to the muscularis. Timely action is important, for at the outset the septic process is limited to the cavity of the organ. Soon it goes beyond local measures. The dull curette is harmless if used with care, as every instrument should be. The practitioner should be as competent to use it understandingly as to use the forceps or insert an irrigation tube.

The method which Dr. Grandin prefers to the repeated douche, and the value of which he has in a number of instances established to his own satisfaction, is the following: As soon as fetor of the lochia appears he proceeds carefully to differentiate its source, and without going into the details of the differential diagnosis it is sufficient to say that a thorough vaginal douching with boiled water or antiseptic solution will cause this fetor to disappear, in case it is due to decomposition in the vagina. If the fetor soon returns, also after the intra-uterine douche, it may be regarded as an indication for active treatment. He then places the patient in Sims's position, introduces the speculum, seizes the cervix with the tenaculum, inserts the curette, and thoroughly scrapes out the interior of the uterus. Finally he gives another douche, and then confidently expects to see a marked change for the better within twenty-four

hours. Thus will be accomplished at once by the curette all that the douche can do if continued days. He deprecates as much as anyone unnecessary interference with the genital tract after labor, but when the necessity arises he believes in speedy action. It will be observed that he does not advocate the radical measure until the milder ones have been tried and failed. The use of the dull curette is attended with no more danger than the use of the irrigation tube, but if anyone fears it, he may resort to Doléris's brush.

The paper was discussed by Drs. Janvrin, Currier, R. A. Murray, Jacobus, and others, who agreed in the main with the author.

PERISCOPE.

Pelvic Peritonitis.

In the *American Journal of Obstetrics*, September, 1888, Dr. Joseph Eastman states that from his experience in the past year he feels warranted in emphasizing the importance of pelvic peritonitis—a disease often overlooked, yet the most common disease of the female pelvis. According to the text-books, pelvic cellulitis more frequently follows labor than pelvic peritonitis. Post-mortem examinations, and, within the past few years, abdominal sections, are demonstrating that without some pre-existing peritonitis, the trauma of child-birth, and other causes heretofore related, would less frequently result in cellulitis. He refers to the autopsies (for all diseases) made by Winckel — well-marked pelvic peritonitis was found in one-third of the cases. The same authority found pronounced disease of the Fallopian tubes in 182 cases, out of a total of 575, which were examined *post-mortem*. These instructive statements should lead to the early medical treatment of salpingitis, which so frequently causes inflammation of structures contiguous to the tubes owing to their movements and periodical engorgement.

The sharp stitch-like pains felt by young women before, during and after menstruation are, as in the chest, significant of more or less inflammatory adhesion of some portions of the serous covering of the pelvic structure. The term pelvic peritonitis may be applied to a circumscribed spot of inflammation, or signify coexistence of perimetritis, perisalpingitis, perioöphoritis, pericystitis, and periproctitis. The delicate silky membrane at first becomes opaque, then adheres to the fold of peritoneum nearest in contact. Thus the uterus, rectum, tubes and bladder may become adherent one to the other, or all together: and each recurring attack of inflammation strengthens the adhesions. The serum poured out may become purulent, forming abscesses in the broad ligament, or between coils of intestines; these seriously impair various functions, sometimes causing intestinal obstruction. Should they discharge into the bowel or bladder the ultimate cure is seriously complicated.

Congenital defects in the sexual organs may favor the development of peritonitis. The brain-cramming of our school systems is also a predisposing cause, since it interferes with the normal development of the pelvic organs in young girls. Allusion is made to the observation of Tait that disease of the tubes is at times due to the exanthemata, which probably act by causing catarrh of the tubes, or by interfering with the proper development of the epithelial lining of these organs. Dr. Eastman has removed diseased tubes from several cases in which the history clearly showed that scarlet fever was the cause of the disease. While gonorrhœa is admitted to be a frequent cause of pelvic peritonitis, the extreme views of Noeggerath and Saenger are not accepted. Still there is reason to shudder at the fate of marriageable young ladies when it is remembered that a large percentage of marriageable young men have suffered from gonorrhœa, and have been imperfectly cured, or rather, not cured at all. The teaching, heretofore extant, that gonorrhœa in the female is less serious than in the male is wrong, *and must be rewritten*. The statement of Van Buren and Keyes that "gonorrhœa sends more to the tomb than syphilis" is quoted with commendation, and it is added that the same foul virus sends twice as many women to the grave as men. While serious lesions in the urethra (resulting from gonorrhœa) are less common in the female than in the male, the Fallopian tubes and ovaries furnish a secret lurking-place for the gonorrhœal virus, where its work of destruction is beyond the reach of remedial agents. Means used to prevent conception, especially cold water injections used after coition, cause many cases of tubal and ovarian inflammation. Induced abortion is a prolific cause of peritonitis from which many deaths result.

The treatment given refers more particularly to advanced stages of the disease, in which operative treatment alone offers a prospect of benefit or cure. Opium is still

accorded the first place in the treatment of acute peritonitis; but we are warned against its use in chronic cases, lest the "opium habit" be induced. Hot applications to the hypogastrium, combined with hot antiseptic vaginal douches, given with the Hildebrandt douche (which instrument allows the use of water ten or fifteen degrees hotter than can be borne by the external parts) are also regarded with favor.

In case that each recurring menstrual period rekindles the inflammation, removal of the uterine appendages, to relieve the pelvis of its periodical congestion, is undoubtedly a warrantable operation if all other methods of treatment have failed. [Are not the appendages removed as the *fons et origo mali* rather than to bring on the menopause, and when peritonitis is caused by pyo-salpinx is it not warrantable to remove the appendages before employing all other methods of treatment?—ED.] In answer to the claim that the uterine appendages are being removed without sufficient cause, Eastman states that from his limited experience he believes that for every case in which these structures have been removed, unnecessarily, ten women have gone to the grave whose lives could have been saved by timely removal of the appendages by skilful hands.

The attention of those who condemn salpingo-oöphorectomy is called to the following propositions, and they are requested to use anatomical, physiological, pathological, and therapeutical common sense in the consideration. Could the ovaries and Fallopian tubes, like the testicle and epididymis, descend during early life and remain within reach of poultices, iodine, suspensory bandages, etc., and if they could remain free from monthly engorgement, they also might be relieved of congenital defects, physiological abuses, the destructive sequelæ of mumps, the fevers of childhood, and the pernicious gonorrhœa virus, before disorganization had so far advanced as to necessitate their removal. After suppuration has occurred, whether the pus is discharging by the rectum, vagina or not, the treatment instituted by Tait—to open the abdomen, drain the abscess from its fountain source (whether in the broad ligament or between coils of intestines) by stitching the peritoneal margins of the abscess to the abdominal wound and using the drainage tube—is considered the safest and most satisfactory method of treatment. It is preferred to opening the abscess *per vaginam* with the trocar or bistoury; also to enlarging sinuses communicating with the vagina and rectum when such exist. Martin's method of drainage through Douglas's pouch may be more suitable in some cases.

Rupture of the Quadriceps Extensor Femoris.

Dr. W. R. Cluness, in a letter to the *Sacramento Medical Times*, Nov., 1888, says: The subcutaneous rupture of muscles or tendons is a comparatively common occurrence, the rupture usually taking place at the junction of the muscular with the tendinous tissue. Erichsen says that it occurs more frequently from the muscular contraction, which must necessarily precede it, than from direct violence. Gross, Ashhurst, and indeed all of the authorities I have found it convenient to consult upon the subject, convey the idea that much force is always necessary to cause this kind of injury, especially when a muscle or tendon of considerable size becomes ruptured. The few cases that have heretofore come under my observation confirm this view, or indicate that sudden and unexpected tension is necessary, even when not accompanied by very great strain. When therefore the complete rupture of so powerful a muscle as the quadriceps femoris takes place during the ordinary efforts of walking, and without stepping upon a pebble or other similar substance, or in any manner encountering an obstruction which would in the slightest degree impede locomotion, it is deemed worthy of permanent record. The history of such a case is briefly as follows: G. W. D., 75 years old, 5 feet 8 inches in height, and weighing 188 pounds, a well-preserved and robust man, apparently ten years younger than he really is, and of good habits, while returning from a few hours' recreation at fishing in the Sacramento River on the 20th of last month, and while carrying a small string of fish in his left hand as he was slowly wending his way homeward, distinctly heard a snap, as if his thigh bone had been broken. Falling backward instantly, he endeavored to prevent himself from sustaining injury by quickly throwing his arms behind him for support, but so sudden and unexpected was the seizure that he fell to the earth before he could realize what had occurred. He says: "I first heard a crack, and away I went, heels over head, turning a complete somersault; I then flopped around on my face and tried to get up, but could not; I tried again and failed.

By this time I realized that my leg was paralyzed, and I called for the assistance of the Yard-Master of the S. P. Co., who soon placed me in a hack and sent me home." Upon reaching his home I was immediately summoned, and readily diagnosticated a rupture of the quadriceps femoris at its insertion into the patella, the separation being complete and the detached end being distinctly felt fully two inches above the upper border of that bone. Treatment for the first two weeks consisted in the relaxation of the ruptured muscle, by position, and the application of an evaporating lotion to subdue what inflammation might ensue. There having been but little pain at any time, no anodynes were required. He is now, just a month after the accident, able to move about in his room upon crutches, the limb being properly bandaged, and the joint rendered immovable by suitable appliances.

Resins used by the Ancient Egyptians.

A small jar of resin was recently submitted to Mr. E. M. Holmes for identification by Mr. Flinders Petrie, of the Egypt Exploration Exhibition. This jar, which was in a perfect state, was disinterred from a heap of rubbish found among the ruins of Naucratis and dates from the sixth century B.C. Naucratis was at this time the only Greek colony in Egypt, and it was through this town alone that trade with Greece was permitted. Mr. Holmes states in the *Pharmaceutical Journal* that the jar contained Chian turpentine. According to Flückiger there is no evidence that the old Egyptians were acquainted with the resin. The discovery of this pot of resin carries the history of the commerce of the drug two hundred years further back. The other resin was found on a mummy cloth on the body of a person to all appearance of some rank. It was found in Hawara Cemetery, in the Fayum province of Lower Egypt, and it dates from a period not earlier than the second century A.D. On heating some of the resin in a flame, the vapors of benzoic acid were given off, and a decided vanilla odor was recognized. This points to the conclusion that the resin must be a Siam benzoin. The authors of the Pharmacographia state that there is no evidence that the Greeks and Romans, or even the earlier Arabian physicians, had any acquaintance with benzoin.—*Lancet*, Nov. 24, 1888.

Value of Salicylic Acid in Dermatology.

At the meeting of the American Dermatological Association, at Washington, Sept. 18, 1888, Dr. C. Heitzman, of New York, read a paper on the value of salicylic acid in dermatology, in which he said that he had been using the remedy for the last three years. It has two well-marked properties. The first is the peculiarity of acting on the horny layers of the epidermis. There is no agent so active in softening, and at last destroying, the epidermal formations as salicylic acid. Its other action is as a parasiticide. These two properties open a large field for research. We should be careful not to include cases in which we have merely impressions as to its value; but there are many cases in which there can be no question as to its utility, and in some of these it has never been used before. The remedy may be used as a powder, as a plaster, or in the alcoholic solution. It has the advantages that it does not discolor the skin or linen, and has no odor. It is used in twenty-four kinds of cases. In hyperidrosis its action is well known. The German soldiers use it in a one per cent. salve, made with tallow, applied to the feet when upon the march. In seborrhœa, especially when combined with acne, it has given brilliant results. One per cent. of the acid with six to eight per cent. of sulphur, is an excellent application for dandruff. A prescription with tar Dr. Heitzman likes better, but it is less agreeable to the patients. In urticaria it is an excellent means of allaying the itching. In furunculosis an ointment of six to ten per cent. has prevented an outbreak and checked the disease. But, to be sure of results, the quality of the acid must be guaranteed. In two cases in which the prescription had been filled at random there had been no good result, but when Scheering's salicylic acid was substituted the effect was immediate.

In one case of dermatitis herpetiformis a lotion of the acid proved the best thing the patient had tried, although it was not capable of smothering the disease or preventing recurrences. In psoriasis, after chrysarobin and tar, it is the very thing to be applied, though the peeling off of the scales is not so rapid as with other remedies. In lichen planus salicylic acid is far superior to carbolic acid or corrosive sublimate. It can also be applied over a larger area with safety. It allays the itching, removes the scales, and flattens down the papules. The author has prescribed three per cent. solutions, which are to be diluted at the beginning of treat-

ment. Six cases were treated, and all did uniformly well without the administration of arsenic.

In all varieties of eczema the results were satisfactory. Ninety-six cases were treated, generally with one per cent. of the acid, with equal parts of zinc-powder and starch, in two parts of ointment. In eczema madidans, one-half per cent. is better. Sometimes it may be used as strong as ten per cent. where there is great thickening in the very chronic cases. As the acid does not attack the connective tissue, there can be no caustic effect. In acne a three per cent. solution removes pigment patches, assists in removing comedones, and renders the skin soft. In acne rosacea the results were good, but in sycosis less good. The remedy does not seem to penetrate deep enough between the furrows. In impetigo contagiosa it cures the disease in ten or twelve days. If combined with the liquor gutta-perchæ and some oil to make an emulsion, it adheres to the skin. In keratitis senilis, callosity, clavus, and verruca its action in removing the thickened portions is well known. In ichthyosis it is easy to remove the scales, but they return. In lupus erythematosus and lupus vulgaris the results were brilliant at first, the excrescences flattening down rapidly at first, but not a case was cured. For pruritus, in the shape of a lotion, it is excellent. In tinea the solution with gutta-percha is better than Taylor's remedy. But generally the disease will not be cured by any one remedy, and we are only too glad to have more than one. In tinea versicolor a one per cent. solution is effective.

Dr. Pye Smith, of London, spoke of his use of the remedy in the hypertrophic inflammations in the soles of the feet and the palms of the hands where there were fissures; here the effects of the remedy are wonderful. He corroborated what Dr. Heitzman said in reference to the use of the remedy in furunculosis, especially as it occurs in youths or school-boys, sometimes for months together. He believes that the contagion is carried from one point to another in the dressing. In the treatment of the individual pustules he always hardens the surrounding skin by bathing it in lead lotion, thus giving less opportunity for the invasion of the micro-organisms than does the old method of poulticing, which makes the skin sodden and readily permeable. In lichen planus he has tried the salicylic acid with some success. but has found it difficult to follow the cases closely enough to be sure of his ground. He prefers to wait till more material has been collected. In general, he said he felt that there were not enough cases to warrant definite conclusions.

Dr. L. D. Bulkley, of New York, said he had used the remedy largely in many of the cases referred to, and mentioned particularly hyperidrosis of the axilla in women. He uses with great confidence a ten per cent. powder, with one drachm of oxide of zinc and the rest starch. In eczema care must be used. He has seen acute attacks started up by it. He also mentioned favus of the scalp, in which he considers salicylic acid very valuable in the form of a strong lotion. He has had several cases under observation for several months, and the disease has not yet returned. It is good in seborrhœa, but, if it is too strong, even when mixed with oil, the patients come back and say it is too drying.

Dr. A. Van Harlingen, of Philadelphia, uses it in the treatment of chronic eczema of the legs in a paste with glycerine and zinc oxide, made into a paste with five per cent. of the acid. If it is carefully applied, the patients go for from three days to a week without redressing.

Dr. E. B. Bronson, of New York, thinks that in most cases we use the remedy as a preliminary measure, as it prepares the surface for other remedies. This is true especially where there is an enormous accumulation of the epidermis, as in cases of seborrhœa. In these cases he has generally been obliged to resort afterward to some other remedies.

Dr. Heitzman, in closing the discussion, said that the field of the remedy in hyperidrosis extends to any portion of the body which is affected, especially the folds of the groin and the genital regions.—*N. Y. Med. Journal*, Dec. 1, 1888.

Formula for Chronic Cystitis.

At the meeting of the Sacramento Society for Medical Improvement, Oct. 16, 1888 (*Sacramento Med. Times*, Dec., 1888), Dr. Mary J. Magill read a paper on the treatment of cystic disease in women, in the course of which she said that the following formula had proved very serviceable:

℞ Ol. cubebæ,
Ol. santali,
Ol. copaibæ . . . . . aa ʒiii
Liq. potassæ . . . . . fʒiss
Syr. acaciæ,
Aquæ anisi . . . . . aa fʒiiiss

M. Sig. Two teaspoonfuls every 4 hours.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterise communications intended for publication.

REGULATING VETERINARY MEDICINE.

A committee of well-known practitioners of veterinary medicine in Philadelphia and other parts of Pennsylvania has recently drawn up an address to the Legislature, recommending to its attention the importance of adopting some measure to regulate the practice of veterinary medicine in the State. The address recites the value of the cattle in Pennsylvania, which is put at about one hundred and twenty-five million dollars. In addition to this, the committee dwells upon the danger of communication of tuberculosis from animals to man.

In doing this they have fallen into an exaggeration which may do their cause harm. This is to be regretted, because their cause is a good one, and could be maintained on its merits. There can be no serious question of the importance of legal regulation of the practice of veterinary medicine, as all enlightened communities ought to regulate the practice of medicine among human beings.

At present a large part of the practice of veterinary medicine in this country is in the hands of uneducated and even ignorant men; and animals are often subjected to medication, and other treatment, which is barbarous and worse than useless. To remedy this condition of affairs, the State should use its influence and authority to compel those who wish to enter this calling to prepare themselves by study in some of the excellent schools to be found in this country or abroad; and it is plainly its duty to protect its citizens against the malpractice of those who have no right to assume the responsibilities of veterinary medicine.

With some modifications, the bill proposed by the Committee we have referred to would do a great deal to this end, and it would also furnish a much-needed stimulus to the study of veterinary medicine, by making the title of veterinary surgeon more honorable than it is now. There is, we believe, a great opportunity in this country for the ambition of first-rate men in the study of the nature and treatment of diseases of the lower animals. So far, few men of ability and promise in the United States have cared to devote themselves to this pursuit; but more will do so whenever it is understood that such a course opens up a most inviting field for scientific investigation and an excellent one for financial success.

The bill proposed will tend to elevate the standing of veterinarians in the community, and to encourage the kind of men to study veterinary medicine who are most needed in this department of science, for the good of the community and for the credit of their calling.

THE PROGNOSIS OF CARCINOMA AFTER OPERATION.

No one who is familiar with the recent advances in surgery can fail to appreciate the change which has taken place during the last ten or fifteen years in the attitude of surgeons toward the treatment of patients suffering with cancer. The time was, and not so long ago, when surgeons regarded the removal of a carcinoma as an operation involving great danger to the life of the patient, and as furnishing but a temporary and brief freedom from active manifestations of the disease. Nowadays the methods of wound treatment have been so perfected that the danger to life is reduced to a minimum, and it hardly enters into the calculation of results, except when the cancer occupies some peculiarly dangerous position.

The final result of an operation for cancer falls under one of three heads: first, perfect success, when a patient recovers from the operation and lives for years without any local or remote recurrence; second, partial success, when the patient recovers from the operation and lives for a period of months before recurrence takes place; and, third, failure, when the patient dies soon after the operation, or suffers with local or distant recurrence of the growth within a very short period.

In looking over the whole field, using statistics in a legitimate way, and giving due weight to what is of equal worth, namely, the opinions of skilful and experienced surgeons, it appears that the modern method of early and complete removal of cancerous growths has very much improved the chances of those who suffer with them.

The number of those who seem to be absolutely cured, and who prove this by freedom from disease for ten or more years, is exceedingly small; and there seems to be no period of freedom long enough to be a sure sign of cure; but the number of those who are freed from active manifestations of carcinoma for months is relatively very great. In an address before the Seventeenth Congress of German Surgeons, Professor König, of Göttingen, estimated the proportion of patients temporarily cured as high as thirty per cent.

This large percentage of comparative cures is not found in operations for cancer of the mucous passages, such as the larynx or the rectum, because in these situations a cancer is sometimes very hard to approach and hard to extirpate thoroughly, and its removal causes functional defects which are in themselves very dangerous to life. Besides this, cancers in the breathing passages, or the digestive tract, are not, as a rule, brought to the notice of the surgeon until they have already assumed formidable proportions. But, even in the case of cancers of the rectum, it is encouraging to note that the mortality has within the last ten years fallen to nearly one-half what it was formerly.

In view of these facts, the outlook for persons afflicted with cancer is very much more hopeful than it was a decade or two ago. The methods of operating are much less immediately dangerous to life, and the prospect of temporary relief from the distress and horror of a cancer is much greater.

It is very important, in estimating the value of operations for cancer, to measure, not only the months or years of life which can be credited to them, but also the amount of peace and comfort which they secure for the patient, the hope—even though it last but a comparatively short time—which succeeds to the hopeless despair of one who denies himself, or who is denied, the chances of an operation.

When all these factors are taken into consideration, we may regard with great satisfaction the attainments of the last ten or fifteen years in this field, and entertain a reasonable hope that the future may develop more accurate methods of diagnosis of carcinoma and more successful methods of operating for its relief, with a correspond-

ing improvement in the prospects of those who are the victims of its ravages.

FLUORINE AS A REMEDIAL AGENT.

The recent active search for new remedial agents has led to the introduction into medical practice of a number of new remedies, some of which have proved of real value, while others have only seemed for a time to be of service, and on more extended experience have proved of little worth. One of these agents is fluorine, an element which is well calculated to attract attention on account of its remarkable chemical properties.

In a temperate and thoughtful article in the *Deutsch-Amerikanische Apotheker Zeitung*, November 1, 1888, Dr. Theodor W. Schaefer, of Kansas City, Missouri, calls attention to the characteristics of fluorine and its compounds, and discusses its use as a medicament. He refers to the experiments of Dr. Eduard Wernigk, of Alhambra, California, who used it with satisfaction in the treatment of epilepsy, and, by subcutaneous injection, in a variety of tumors. The form which he found most serviceable was the fluoride of potassium, half-grain doses of which in solution proved of decided value in the treatment of an osteoma of the lower maxillary bone, in a fibrous tumor of the face, and in a lupoid growth of the hand. Dr. Schaefer himself used hypodermic injections of fluoride of potassium in a case of goitre, with encouraging results, and applied the remedy by pencilling and by gargling in a case of diphtheria, which ended in recovery. These cases cover the ground in which Dr. Schaefer has so far found the compounds of fluorine to be useful.

As a remedy for internal administration, the salts of fluorine have not yet given any specially good results. It has been used in certain affections of the heart, but without much success. Dr. Da Costa, of Philadelphia—whom Dr. Schaefer erroneously locates in New York—some years ago made a number of interesting experiments in the use of certain fluorides internally, and published the result of his investigations in a very instructive paper in the *Archives of Medicine*, June, 1881. This paper was a report of the first systematic attempt to use the salts of fluorine in medical practice. The salts Dr. Da Costa chiefly made use of were the fluorides of potassium and of sodium, and the ferrous and ferric fluorides. His observations led him to the conclusion that the preparations of fluorine are too irritating to the stomach to be of much value, and—as we have ascertained by personal inquiry—he does not now have a high opinion of their availability in therapeusis.

From all this it appears that the investigation of the effects of fluorine upon the animal economy has not yet led to any very important developments, and yet it certainly invites to further study. Theoretically one would expect that an agent which has such marked chemical peculiarities must have effects upon physiological and pathological processes not less marked. If heretofore it has not proved of much service in the treatment of disease, this may be because it has not been studied carefully enough or generally enough, and Dr. Schaefer has done a good thing in calling attention anew to what has been done in this direction, and in inviting the profession to pursue the investigation further.

ACCOUNTS RENDERED QUARTERLY.

There was a time when the services of physicians were not considered as an article of merchandise, with a fairly definite price, but rather as acts of benevolence and humanity, and then grateful patients signified their appreciation of these services by gifts in the nature of an honorarium. But this time has passed away, and now every medical man is compelled to keep accounts, and periodically to try to collect what he believes is due him by the unromantic method of sending out bills.

No physician need be told how troublesome and often how disagreeable a part of

his work this is. The question of what he shall charge is not rarely a trying one; for he cannot always figure out so many visits at a certain price and put this down on his bill. There are many circumstances which may compel him to make his charge less than he thinks it might properly be; and when he has fixed it, he is sometimes troubled to think it may be more—or, alas! less—than his debtor has estimated it at.

In addition to this source of distress there is the question as to the periods at which a physician shall render his accounts. In many parts of this country it has become a custom for physicians to send out bills every six months; and some men send out their bills only once a year. There are advantages in this plan for men of means and of large and lucrative practice; but it has very great disadvantages for the great majority of medical men. It is especially hard on physicians in the earlier years of their practice, because then they usually need speedy returns for their work, and treat a class of persons that requires pretty close watching. But almost all physicians lose by sending out bills only at long intervals. Patients treated with such indulgence sometimes become careless about paying, because from this very fact they imagine the doctor does not need money as they do, and some patients deliberately impose on their physicians as long as they can, and, when called upon to pay what they owe, simply transfer their patronage to someone else until his endurance is exhausted.

These and other reasons which will occur to our readers make it desirable that medical men should—except in rare cases—render bills more frequently than once or twice a year. The proper interval in most cases appears to be three months. This was the conclusion arrived at by the West Philadelphia Medical Society at a recent meeting, when the following was adopted:

"Realizing that the time has arrived when, in order to keep pace with the increasing business sentiments of the world, it is necessary to insist more strongly on the strictly business aspect of our professional services; and, believing that this will be ensured by the rendering of our accounts more frequently than has been the general custom;

"It is resolved, that the West Philadelphia Medical Society deems it to the best interests of its members, and of the profession generally in West Philadelphia, that they shall render their accounts for services quarterly or more frequently, and hereby urges upon them concerted action in this matter, reserving to them discretion to make exceptions in cases in which they may deem it to their best interests or those of their fellow-practitioners."

We fully concur with the sentiment of this resolution and believe it would be a good plan for physicians to render their accounts every three months. There are very few patients who would not approve of such a practice, and it would be a great advantage to medical men if it were generally carried out.

OPERATION FOR STENOSIS OF THE PYLORUS.

Operations for stenosis of the pyloric orifice of the stomach are no longer very rare, and a variety of methods have been proposed for treating this condition surgically, among the most promising of which was the method of digital dilatation of Loreta. Another method, which has proved of value, was first practised about three years ago by Heincke, and two years later by Mikulicz. A third operation by this method was performed in July, 1888, by Bardeleben, and is reported, with comments by Dr. A. Koehler, in the *Berliner klin. Wochenschrift*, Nov. 12, 1888. The method consists in opening the abdomen, dividing the stricture longitudinally, and then drawing the wound apart vertically so that the horizontal open-

ing is converted into a vertical one, after which the wound is united with a continuous suture. In this way the contracted tissue is made to occupy only the posterior wall of the newly formed canal, while its anterior wall is largely made up of the healthy tissue of the stomach and duodenum.

Bardeleben's operation was performed on a man, thirty-five years old, who a month before had swallowed some strong hydrochloric acid. The time consumed in the operation was only half an hour, and its result was entirely successful.

EXECUTION BY ELECTRICITY.

The law to execute criminals by electricity in the State of New York, which has just gone into effect, has led to some interesting discussion in regard to its merits and demerits. Among others the editor of the *Electrical Review* states his opposition to the law, on the ground that the execution of murderers by electricity is "an unnecessary and an unwarranted debasement of one of the most enlightening elements of the age, and that he does not believe that it is practical from a scientific standpoint." For the sake of the citizens of New York, we would hope that it may be long before they shall have an opportunity to demonstrate either the correctness or incorrectness of this opinion. Our view, however, is that the application of electricity as a means of execution of criminals is objectionable on the score of its difficulties, its uncertainty, and its effect upon the community. As we have stated before —in the REPORTER of February 11, 1888— we are of the belief that humanity no longer requires any modification in the method of executing the death sentence, and that this attempt to substitute electricity for the usual method is not in accordance with the dictates of sound policy nor justified by anything which physiologists know of the sensations connected with death by hanging.

INOCULATION FOR YELLOW FEVER.—Doctor Paul Gibier, a French experimenter, who has been studying yellow fever in Florida, proposes to establish an experimental station for treating this disease. He thinks that a safe method of inoculation will result in the prevention of the disease, and suggests that a laboratory should be established on one of the keys off the Florida coast, and a year spent in experimenting with the inoculations upon monkeys, thus perfecting a method of treatment of the fever.

BURN-BRAE VINDICATED.—Some time ago a patient suffering with acute mania was admitted to Burn-Brae, a private hospital for the insane near Philadelphia. After his dismissal he made complaint of harsh treatment and improper detention against the physicians in charge. The Committee on Lunacy of the State Board of Public Charities has investigated the complaint and has found no justification for it. In concluding his report for the Committee, the chairman, Dr. Thomas G. Morton, said that there was ample evidence to show that the patient's treatment was proper, and his recovery rapid, complete, and satisfactory.

PHOTOGRAPHY OF THE MALE BLADDER.—According to the *British Medical Journal*, Dec. 22, 1888, Mr. Hurry Fenwick, and Mr. Pearson Cooper of the London Camera Club, have been working for some time at photography of the human bladder. Various obstacles were in turn recognized and overcome, and they have now so far perfected their vesical camera and method as to obtain good negatives of the interior of "dummy" and dead bladders. They hope before very long to describe a method of recording the appearances and progress of diseases of the living bladder. The negatives are taken *per urethram* through a tube of 23 French calibre.

—The United States Steamer Yantic, which was recently sent on Government business to Hayti, is on its way home with yellow fever on board.

PAMPHLET NOTICES.

[Any reader of the REPORTER who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request stating where the notice was seen and *enclosing a postage-stamp.*]

173. THE SIGNIFICANCE OF THE EPIBLASTIC ORIGIN OF THE CENTRAL NERVOUS SYSTEM. By GEORGE W. JACOBY, M.D., New York. From the *New York Medical Journal*, May 5, 1888. 15 pages

174. ACCIDENTS INCIDENTAL TO THE USE OF THE EXPLORING NEEDLE FOR DIAGNOSIS. By HERMANN M. BIGGS, M.D., New York. From the *New York Medical Journal*, August 18, 1888. 12 pages.

175. OSTEOPLASTIC RESECTION OF THE FOOT. By FERDINAND H. GROSS, M.D., Philadelphia. From the *Medical News*, October 27, 1888. 7 pages.

176. MEMORIAL OF DR. NATHAN LEWIS HATFIELD. By ROBERT J. HESS, M.D., Philadelphia. 8 pages.

177. ENTEROSTOMY FOR ACUTE INTESTINAL OBSTRUCTION. By B. FARQUHAR CURTIS, M.D., New York. From the *Medical Record*, September 1, 1888. 12 pages.

178. THE FAILURE OF DR. J. B. THOMAS'S TREATMENT OF URETHRAL STRICTURE BY ELECTROLYSIS. By ROBERT NEWMAN, M.D., New York. From the *Journal of the Amer. Med. Association*, September 8, 1888. 15 pages.

179. REMARKS ON PELVIC INFLAMMATIONS AND THE MANAGEMENT OF THEIR RESIDUES. By WILLIAM WARREN POTTER, M.D., Buffalo, N. Y. From the *Buffalo Med. and Surg. Journal*, July, 1888. 16 pages.

173. Dr. Jacoby's pamphlet contains his presidential address before the New York Neurological Society, in May, 1888, and presents an argument in favor of the view that the nervous system of vertebrates, although formed from the epiblast of the embryo, like the skin and surface epithelium, has lost its epithelial character and has returned to a state of indifference in which it is impossible to decide whether a tissue is epithelial, therefore epiblastic, or connective tissue, therefore mesoblastic.

The whole paper is exceedingly interesting, and contains very instructive suggestions as to the development of the organs of sense.

174. Dr. Biggs protests against the indiscriminate use of the exploring needle for diagnosis when other means give more reliable information. The dangers of the use of the exploring needle rest upon the traumatism produced and the risk of septic infection. The cases cited by Dr. Biggs indicate that the exploring needle should be used with caution; although it would be going too far to admit that they all illustrate the danger of its use. His warning, however, is timely and may be commended to the attention of our readers.

175. Dr. Gross describes an operation such as has been but rarely performed in this country, and not often in any country, namely that originally done in 1871 by Wladimiroff, of Russia, and independently, in 1880 by Mikulicz, of Vienna. Dr. Gross's operation was successful as far as reported; but it would be interesting to know how good use of his foot the patient has to-day.

176. This is a warm tribute by a personal friend to the virtues of a well-known medical man of Philadelphia, whose life of eighty-four years was full of useful and kindly ministration to his fellow-men, and of pleasant relations with his professional brethren.

177. Dr. Curtis has made a careful study of sixty-two cases of the formation of an artificial anus—for acute intestinal obstruction—all that he has been able to collect from medical literature—and gives the result of his analysis of their various features. It is an interesting statistical study, and of great practical value. It leads the writer of the paper to the conclusion that enterostomy is preferable to laparotomy except when the patient's condition is so good that he can bear the shock of the latter operation, and when the intestines are not so greatly distended as to offer a serious obstacle to a thorough exploration of the abdominal cavity.

178. Dr. Newman defends himself, and the operation which he advocates and practices for the cure of stricture of the urethra, against the criticisms of Dr. J. B. Thomas, of Pittsburgh, who failed to cure a case by electrolysis, and in his report of it discussed Dr. Newman's earlier report of his own experience. The defense is warm and interesting; and it is fair to say that its warmth is warranted by the terms used by Dr. Thomas in discussing Dr. Newman's methods.

179. Dr. Potter's paper presents a temperate and intelligent study of the various views as to the nature of inflammations in the pelvis of women, and a brief review of their proper treatment. The writer cites the opposing opinions of a number of well-known gynecologists, and endeavors to bring out the truth contained in what seems contradictory. The result is a very entertaining and suggestive paper, which may be recommended to the attention of our readers for their careful consideration.

LITERARY NOTES.

—We have received the Catalogue of the Tokyo Medical Library. The library contains 1092 well-selected books and pamphlets.

—After January 1, 1889, Dr. D. A. Hodghead will succeed Dr. William S. Whitwell as Editor of the *Pacific Medical and Surgical Journal.*

—*The United Service* appears in a new series for January, 1889, with the name of L. R. Hamersly & Co. as publishers. It is a handsome large octavo of 116 pages, containing a number of interesting papers by military and naval officers, and the announcements of the editor and of the publishers, short notes, and news of the Loyal Legion. Those of our readers who have served in the army or navy will be interested to know that the publication of this journal has been resumed, and that it promises to be more interesting in the future than it has been in the past.

—From and after the first of January, 1889, *The Canadian Practitioner* is to be published as a semi-monthly, instead of a monthly, as heretofore—twenty-four issues in the year being given, instead of twelve. *The Practitioner* is now about to enter on its fourteenth year, and its history has been one of steady progress and development. At the beginning of 1888 a great improvement was made in the typographical appearance and material make-up of the journal, and its prospectus for the coming year promises still further advances. The subscription price remains what it was formerly: $3 00 a year.

CORRESPONDENCE.

The Porro-Cæsarean Method of Mr. Lawson Tait, historically examined.

TO THE EDITOR.

Sir: In the *British Medical Journal* for November 17, 1888 (see also the REPORTER, January 5, p. 30), we find the following from Mr. Tait: "I have now done four operations on the principle laid down by Professor Porro, and all the mothers have recovered, and the children have all lived. The operation I perform is certainly not Porro's operation, for I have altered nearly every detail."

"My own method of operating is to make an incision through the middle line large enough to admit my hand, and then I pass a piece of india rubber drainage tube (without any hole in it) as a loop over the fundus uteri, and bring it down so as to encircle the cervix, taking care that it does not include a loop of intestine. I then make a single hitch and draw it tight round the cervix so as completely to stop the circulation. I give the ends of the tube to an assistant, who keeps them well on the strain, so as to prevent the loose knot from slipping, the reason of this being that should there be any bleeding and any necessity for further constriction, I could secure this in a moment, without undoing any knot, and the simplicity of the method greatly commends it. I then make a small opening in the uterus, and enlarge it by tearing with my two fingers, seize the child by a foot and remove it. I then remove the placenta, and by that time the uterus has completely contracted and is easily drawn through the wound in the abdominal wall. The constricting tube will now probably require to be tightened, and the second hitch of the knot may be put on at the same time, and the work is practically done. Stuff a few sponges into the wound to keep the cavity clear of blood, and pass the knitting needles" (2) "through the flattened tube and through the cervix, and in this simple way a clamp of the most efficient kind is at once made. The uterus is removed about three quarters of an inch above the rubber tube. The usual stitches are put in, the wound closed round the stump, which of course is brought to the lowest part of the opening, and then the stump is dressed with per-chloride of iron in the usual way."

This is certainly in many respects, an excellent way to operate, and Mr. Tait has shown his wisdom by accepting and grouping together a series of alterations made and tested before he ever operated. His altering, does not mean, that he claims to have originated the alterations. The Esmarch tube and transfixing pins are in very frequent use.

The opening of the uterus *in situ*—the delivering of fœtus by the feet—the constriction of the cervix—and securing the stump in the wound after its amputation, are the points of the operation as performed by Prof. Porro. The alterations in the details are as follows.

1. *The constriction of the cervix, after the manner of Esmarch;* as applied first by Prof. Litzmann of Kiel, now of Berlin, in case 15, in chronological order, on June 14th, 1878. The elastic ligature was used to continue the constriction, instead of the *serre nœud* or clamp. Elastic ligation was also employed in case 71, Dec. 7, 1880, under Dr. J. De Rull of Barcelona, Spain, and in case 72, of the same date, by Prof. Hegar, of Freiburg, Germany.

2. *Opening the uterus by small incision and enlarging the opening by digital laceration;* as introduced by Dr. Clement Godson, of London, on November 27, 1882; who says in his report, "I made" . . . "a small incision, large enough to admit the finger" . . . "I immediately inserted the tips of each fore-finger, and tore the womb open transversely." There is no necessity to teat the uterus, where the elastic tube of Esmarch is used.

3. *The transfixing of the cervix by two long pins or knitting needles.* Prof. Chiara of Milan lost a case in December, 1877, by the stump falling in and the bowels protruding, as the result of vomiting: in his next operation, May 22d, 1878, he made use of one transfixing pin as a preventive. Six days later, Prof. Domenico Tibone, of Turin, introduced the plan now in general use, of employing "two long transfixing pins." It is also the custom of some operators to stitch in the cervix with the abdominal wound, to secure an early and intimate union, as a means of safety.

Half-knotting the Esmarch tube, as practised by Mr. Tait, is better than whole knotting it, and then being obliged to untie and retie. Clamping the half-knot by strong pressure-forceps is a common mode of security. Passing the pins through the tube instead of beneath it, belongs to Mr. Tait. As the pins come away with the tube when the stump separates, they will fail of the purpose for which they were originally

introduced in Italy, if separation should happen to take place too early. The pins fix the stump, and secure it from being kept in slipping motion excited by vomiting, by respiration, and the dragging upon it from within, all of which have a tendency to delay union. The chief value of the pins is in the first few days, and their office ceases with the union of stump and abdominal wall: hence the additional advantage of cervico-abdominal suturing, through the tissues which are to remain after the pins come away. Much temporary disfiguring of the abdomen in the line of the cicatrix, by its being deeply drawn in, remains in many cases. Where there is extreme antero-posterior pelvic collapse, as in rickets, and the sacro-vertebral angle is so altered as to bring the plane of the superior strait nearer in parallelism with the abdominal wall than normal, there will be the least vagino-cervical tension, and *vice versa*, when the pelvis is normal, as in tumor cases. In time, the stretching of the stump within, relieves the abdominal wall from being deeply indented.

The Porro-Cæsarean operation is much more of a principle, than of a special method devised by the Pavian professor, and departures from the technique of his original plan, do not in the least weaken the claim which associates his name with the operation as a whole. Prof. Porro designed to save life, by giving the uterus a form of wound after a Cæsarean delivery, that might be dressed outside of the abdominal cavity, and by which septic peritonitis could be avoided. The quasi unsexing of the woman was scarcely to be considered; as her living, to become again pregnant, after the old operation was a great rarity in Italy. Her being made sterile is now claimed as an advantage by many operators. Professor Porro by saving five women out of a record of six, has shown, that his own technique has a high capability of securing success. As supra-vaginal hysterectomy existed before Prof. Porro applied it in parturient cases, it is an error to attach his name to any hysterectomy case which is not "completive of the Cæsarean section." To remove an unopened uterus for tumor, and with it a fœtus in the early months, is not strictly a Porro operation, and such cases have no claim to enter into a statistical record of Porro cases, as the fœtal column can have but one result, and that a fatal one: the same may be said of hysterectomy following a rupture of the uterus.

The Porro-Cæsarean section has at this time an additional interest from the fact, that the records of the last four years show a very decided decrease in the percentage of deaths over that of former years. A full record of 1884, shows 28 Porro operations, with 18 women and 10 children lost. This appears to have been the maximum year for cases, with the exception of 1880, when there were 33, with 22 deaths. Since the introduction of the Sänger method, there has been a gradual falling off in the number of Porro operations, and at the same time an increase in the percentage of women saved under each: viz., in 1885 there were 13 Sänger operations with 4 deaths: in 1886, 33 operations with 10 deaths; and in 1887, 47 operations with 10 deaths. In 1885, there were 22 Porro operations with 5 deaths, and in 1886, 22 operations with 4 deaths. There may be possibly a few Porro cases for these two years not yet collected: the record of 1887 is very incomplete as yet, showing twelve cases, with two deaths and one suicide. The reports of 1888 are thus far equally encouraging.

Mr. Tait strongly advocates the Porro operation in preference to the Sänger, but strangely withholds from publication three cases, that might add force to his claimed preference. As we do not know even the years of their performance, they are as yet useless in the comparison.

Since the above was written, I have learned that Mr. Tait, in an operation performed last June, used the Esmarch tube temporarily; then applied his own modification of Kœberlé's *serre nœud;* and secured the stump by a "fixation pin," like a large hair-pin, with trocar points and caps to cover them. This is, then, his proper and last method of operating.

Yours truly,

ROBERT P. HARRIS, M.D.

329 S. 12th Street, Philadelphia,
December 24th, 1888.

Typhoid Fever in West Virginia.

TO THE EDITOR.

Sir: Since Aug. 1, 1888, we have had an epidemic of typhoid fever here in the mountains. Where it comes from, or what is its prime cause, I am unable to say. The country here I believe to be healthy. We live on a large river—the Clear—in Tucker County, West Virginia, and our drainage is good. There is a new railroad being built through this region, and some believe the typhoid fever is due to the stirring-up of the soil. The water I do not think the best,

and there is a great deal of decaying vegetable matter also through this country.

I have had cases in the healthiest localities and cannot understand it except that, as an epidemic, it must be everywhere. All cases, if sent away in time, soon get well; those that stay generally suffer.

I have talked to my brother physicians on the subject and they give me little satisfaction. I write to ask for information. I am young in the profession, and need help, and wish to learn all I can. The REPORTER helps me, and whenever I see anything of typhoid fever, especially, I at once wish to see if I can get what I wish. Now, tell me: what is it that might have started it here? As far as I can learn, the first case was seen by a doctor some eight or ten miles from this point, some time early in May. The epidemic started on the railroad above this place, among some negro railroad hands. Doctors Porter, Harr, Baker, and I had the camps moved to a dryer place, and soon had no return of the trouble there. It is now all over our country and we still fight it. I have advised cleanliness about the houses and yards, have used disinfectants, have begged the people to use lime, both in and about the houses; but still we are kept on the go to see new cases. Let me hear from the readers of the REPORTER. I would like to hear from other physicians on the subject of typhoid fever—giving the means of preventing its spread and their treatment of cases, etc.

Yours truly,

B. M. SMITH, JR., M.D.

Parsons, W. Va.,
Dec. 17, 1888.

Long Continued Diabetes Mellitus.

TO THE EDITOR.

Sir: I saw in the REPORTER, November 10, 1888, a short article by Dr. Henry C. Coe, about albuminuria in diabetes mellitus and its conclusions. I have at present a patient, 69 years of age, who had for fourteen years glycosuria, and has now albuminuria, but no diabetes any more. It is about a year he developed the nephritis; urine, sp. gr. 1.005, albumin 2 per cent., fatty, hyaline casts, with some blood and pus casts; latterly he commenced to have abundant epistaxis; at one time the attacks continued for a whole week, the patient losing sometimes more than a pound of blood daily. Now he loses a few drops of blood once in a while. His heart is rather weak, and he has slight swelling of the extremities; but his appetite is pretty good, his mind is clear, and he is not at all emaciated. His urine is abundant and acid; and acetone is also present in it. The patient has been formerly a hard drinker. I would not be surprised if he should die of coma. I only cite this as a case of long diabetes, apparently without much harm; but I think this chronic nephritis brought on by the irritation of the kidneys through frequent micturition. Besides, he will not take any medicines nor observe any diet; only when he is much frightened, as in the bleeding from the nose.

Yours truly,

VALENTINE KAUFMANN, M.D.

Catorce, Mexico,
Dec. 7, 1888.

NOTES AND COMMENTS.

Splenectomy.

Mr. G. A. Wright, in a communication on splenectomy in the *Medical Chronicle*, Dec., 1888, says that splenectomy has been performed for the following conditions: painful floating spleen; painful "hypertrophy" of the spleen; malarial enlargement; cystic enlargement, whether from the presence of hydatids or from the development of simple cysts of unknown origin; abscess of the spleen; enlargement in leukæmia; tumor of the spleen. He has collected records of 62 cases. Twenty-two cases of leukæmia were operated on with fatal result in every case except one, which is classed, not as an instance of leukæmia, but of hypertrophy, by Thornton, Collier, and Crédé. This case is that of Franzolini. The cause of death in 12 cases was hemorrhage. In 5 of these the patient did not live more than one hour. Three patients died of shock, one of peritonitis, only one survived for twenty-four hours, and the longest recorded survival was forty-eight hours, except in one doubtful case.

Twenty-three cases are classed as hypertrophy. He suggests that probably in some of these, as in a case of his, there was chronic perisplenitis. Of the twenty-three, 15 died, the most common recorded cause of death being hemorrhage, which killed four patients. The cause of death is, however, not stated in the majority of the cases. In three of the cases that died of hemorrhage, including his own patient, the bleeding came from a vessel in the diaphragm. This was also the cause of death in one of the cases of leukæmia. There is not sufficient evidence to show any

relation between the weight of the spleen and the mortality of the operation.

In seven malarial cases there were five recoveries, if one is included that lived for 35 days, and then died, apparently of old nephritis and peritonitis. In this series there seems to have been no relation between the size of the spleen and the mortality.

Three patients with cystic disease all recovered. Five of unenlarged, or only slightly enlarged, "floating" spleen all recovered. In two of the successful malarial cases the organ was also "floating," as well as in one of the cases of hypertrophy, in which recovery occurred.

The more recent operations in cases of hypertrophy show a marked improvement over the older records.

In the vast majority of cases in which the sex of the patient is recorded the patients were females.

The conclusions at which he has arrived from a study of these cases, he presents as follows: 1. Splenectomy for leukæmia is inadmissible. 2. Splenectomy for hypertrophy is very dangerous, the chief danger being from hemorrhage and shock, and there being especially danger of bleeding from a vessel that passes between the spleen and the diaphragm. Whether it is altogether an abnormal vessel or merely a dilatation of a small vessel existing there, he says he does not know, but it is responsible for the death of his patient, and for that of three others, including a patient with leukæmia. 3. If malarial patients require removal of the organ there is a good prospect of recovery. 4. Cases of floating spleen and of simple cyst are eminently favorable for operation. 5. From a special consideration of his own case, he says that in a patient with simple hypertrophy or chronic splenitis, whichever it may be, a careful examination of the relations of the organ should be made before dividing any vessel, and if large adhesions to the diaphragm are found, and the spleen is firmly fixed, and the pedicle broad and ill-defined, the operation had better be abandoned. It is, of course, impossible to stop if once there is any laceration of the splenic tissue, since the bleeding can only be arrested by removal of the organ. If removal is found to be impracticable after opening the abdomen, the question of ligature of one or more of the main vessels supplying the spleen, is worth considering. Ligature of the splenic artery was suggested by Lucas, but has, so far as Mr. Wright knows, never been tried.

Successful Gastrostomy.

At the meeting of the Southern Surgical and Gynæcological Association, held at Birmingham, Ala., Dec. 4, 5 and 6, Dr. W. B. Rogers, of Memphis, Tenn., reported a successful case of gastrostomy, which he had performed for relief of a patient with cicatricial stricture of the œsophagus. The patient, a white man, 24 years of age, swallowed a solution of concentrated lye one year before the operation. The contraction was situated seven and a half inches from the incisor teeth. The opening was so small that repeated examinations failed to pass it with the smallest urethral bougies. The patient's flesh and strength were rapidly failing from starvation.

Operation, June 29, 1888. Fenger's incision was made; the stomach was held in the abdominal wound by means of hare-lip pins, and stitched to the abdomen with silk. Every aseptic precaution was taken, and the patient recovered without any serious symptoms. On the tenth day, the gastric opening was made, and fifteen weeks later the patient was in excellent health, with flesh and strength fully restored; ability to swallow solid food had gradually returned, and though the opening was not being used, it gave no trouble, the edges having fully cicatrized.

Treatment of Shock.

In some remarks of the treatment of shock, in the *Therapeutic Gazette*, Dec., 1888, Dr. H. C. Wood says that the most characteristic symptoms of shock are the great loss in the force of the pulse, the height of the arterial pressure, and the extraordinary fall of the bodily temperature. He suggests that the unconsciousness which comes very late in shock is due to failure of blood-supply to the brain and the lowering of the temperature of the cerebral mass. The chief cause of the heart failure is the lack of resistance to its contraction caused by the vaso-motor paralysis, which also accounts for the great fall in temperature.

If these physiological views are correct, the two chief indications for the treatment of shock are to overcome the vaso-motor paralysis and to maintain the bodily heat. Stimulation of the heart is, of course, useful, but such stimulation will amount to very little if there is no reawakening of the resistance to the heart action; and if such resistance is aroused in any individual case, it is almost certain that it in turn will re-excite the heart.

With regard to the propriety of giving liquid food in cases of shock, Dr. Wood points out that in severe shock digestion must be in great part, if not altogether, arrested; and the advisability of putting food into the stomach seems to him very doubtful. Raw meat-juice, or better, beef essence, highly seasoned and given hot, is a stimulant rather than a food, and may achieve good at a time when so simple a true food as milk might be actually dangerous.

He advises for the maintenance of body-heat either the hot bath at 110° Fahr., or the hot-water bed. The latter is almost as powerful, he says, as the former, and is free from its objections. If an ordinary water-bed is filled three-quarters full of water at a temperature of 130° or 140°, and blankets spread over it, and the patient laid thereon, his body will sink down so that it will be almost surrounded by the heated mass. If the bed is well covered with blankets many hours will be required for the cooling of the water, so that the body heat can be kept up for a length of time without the patient being disturbed. Dr. Wood says he has found this method of heating the body in collapse extraordinarily efficacious by practical trial.

With regard to the choice of medicines in surgical collapse, he reiterates his well-known opinion that as the action of ether and of alcohol is practically identical, the use of the latter as a stimulant in collapse from the former is improper.

In shock unconnected with anæsthesia, atropine hypodermically is very valuable by virtue of its action as a vaso-motor stimulant. If ergot is used, it should be in the form of the official aqueous extract, five grains dissolved in ten minims of water with two minims of glycerine and ½ minim of carbolic acid. Digitalis, he says, is strongly indicated in shock, not only on account of its power over the heart, but because it appears to be a powerful vaso-motor stimulant. It might be injected directly into a vein in extreme cases; in this case its effect would be immediate but very temporary. Dr. Wood says that he is not aware that anyone has ever proposed the intravenous use of the drug in collapse or shock, but he commends it for trial as practically free from danger, unless over-doses are given, and says it offers the possibility of a brilliant and novel result. Five minims of the tincture diluted with a drachm of distilled water might be *slowly* injected, and repeated or increased *pro re nata*.

Creolin in Eye Diseases.

Dr. J. H. Thompson, of Kansas City, Mo., in a communication to the *Kansas City Med. Record*, Nov., 1888, says that for many years, in certain diseases of the cornea, he has used powdered iodoform and the ointment, which are introduced into the eye two or three times a day in sufficient quantity to bring the antiseptic in immediate contact with the ulcer. In other cases he has had recourse, sometimes exclusively, sometimes in conjunction with the drug mentioned, to an application to the inverted lids and cornea of a solution of the nitrate of silver (1 to 40). The result of this treatment, prolonged two or three months, has been nearly always satisfactory; but to obtain a radical cure it was often necessary to continue the treatment three or four months. He says he has found cases, however, in which this treatment has given but incomplete results; the inflammation diminishes, the functional troubles disappear almost entirely, and the patient is satisfied, believing himself cured; yet when the cornea is examined through a strong lens, small ulcers are seen on its surface, showing that the epithelium has not been completely reproduced. These ulcers, under certain special conditions, may occasion a relapse. Under these circumstances it is imperative that we should seek other remedies which can more completely and certainly destroy the micro-organisms in the cornea.

It is in these cases that he has tried creolin, and he expresses himself as much pleased with it. At present he only speaks of its healing virtues in two cases.

Creolin is a product of the decomposition of coal-tar. It comes now as a brownish liquid, very complex and very impure. It smells like tar, and it is slightly irritating to the cornea, as all the phenols are, for it is strongly acid and slightly caustic. It is probable that before long it will be purified, when it will be as neutral as vaseline, and will then be of even greater value to the ophthalmologist than it is now. Its antiseptic properties are undoubtedly superior to all other drugs at our command.

Dr. Thompson uses creolin in the following manner. A solution is made of:

℞ Creolin . . . . . gr. iss
Aquæ destil. . . . . ℥cl

With a brush dipped into this solution he touches the ulcers once or twice a day, after anesthetizing the eye with cocaine. Sometimes he uses a spray of creolin:

℞ Creolin . . . . . gr. viii
Aquæ destil. . . . . f℥iii

This fluid is sprayed upon the eyeball for a moment or so five or six times a day. With this treatment he has generally obtained rapid healing of the cornea in from one month to six weeks, while with other remedies he has had only incomplete success.

Peripheral Neuritis.

At the meeting of the Nottingham Medico-Chirurgical Society, Nov. 16, 1888, Mr. T. D. Pryce read a paper on this subject. Having discussed the chief types of multiple neuritis, he especially alluded to diabetic neuritis, stating that this disease might occur in two forms: (1) one in which the motor nerve-fibres were chiefly affected, with consequent paralysis; seen in some cases of advanced diabetes; (2) a form in which the sensory, vasomotor, and trophic nerve-fibres were mostly implicated, with consequent and corresponding symptoms. This type closely resembled locomotor ataxia, and also that form of alcoholic neuritis described by Dreschfeld as alcoholic ataxia. Mr. Pryce suggested the term diabetic ataxia or diabetic pseudotabes. He related three cases illustrating this form of disease, in one of which extensive peripheral neuritis was found after death. He considered that the diabetic poison was peculiarly apt to affect the peripheral sensory nerves, and in support of this view instanced the comparatively frequent occurrence of symmetrical neuralgia in diabetes. He further drew attention to a suggestion made by him, two years before, as to the nature of the ataxia which so often occurred in diabetes, and believed that it was in many cases due to a peripheral sensory neuritis. A case of peripheral neuritis associated with phthisis was also related. The patient was a woman, 57 years old, and presented most of the typical symptoms of the disease, namely, pains of varying character, anæsthesia, impairment of superficial reflexes, loss of knee-jerk, tenderness of muscles to pressure, together with muscular paralysis and atrophy. The disease had run an extremely chronic course. Peripheral neuritis was found after death. In this case there was no history of alcohol, syphilis, rheumatism, etc. The paper was illustrated by drawings, photographs, and microscopic specimens of alcoholic, diabetic, and idiopathic neuritis. — *British Med. Journal*, Dec. 8, 1888.

Accidental Rashes in Typhoid Fever.

At the meeting of the Royal Academy of Medicine in Ireland, Nov. 16, 1888, Dr. J. W. Moore made a communication on accidental rashes in typhoid fever. He explained that it was not his intention to allude to the essential rose-spot rash of typhoid fever; or to the more common epiphenomena of the disease connected with the skin, such as *taches bleuâtres*, purpura spots, vibices, and sudamina or sweat vesicles; or, lastly, to the coexistence with typhoid fever of other specific diseases showing characteristic eruptions, such as scarlatina, measles, variola, and, above all, typhus. He desired rather to draw attention to certain other accidental or adventitious appearances of the skin, which were of somewhat rare occurrence, and, from a diagnostic point of view, of considerable importance. These were (1) simple hyperæmia; (2) miliary eruptions; (3) erythematous rashes; and (4) urticaria. Dr. Moore then detailed a series of cases which exemplified the occurrence of these accidental rashes, and summed up as follows: 1. Not infrequently, in the course of typhoid fever, an adventitious eruption occurred, either miliary, urticarious, or erythematous. 2. When this happened, a wrong diagnosis of typhus, measles, or scarlatina respectively might be made, if account was not taken of the absence of the other objective and subjective symptoms of these diseases. 3. The erythematous rash was the most puzzling of all; but the prodromata of scarlet fever were absent, nor was the typical course of that disease observed. 4. This erythema scarlatiniforme was most likely to show itself at the end of the first, or in the third, week of typhoid fever. 5. In the former case it probably depended on a reactive inhibition of the vasomotor system of nerves; in the latter, on septicæmia, or secondary blood-poisoning; or both these causes might be present together. 6. The cases in which this rash appeared were often severe; but its development was important rather from a diagnostic than from a prognostic point of view. 7. Hence, no special line of treatment was required beyond that already employed for the safe conduct of the patient through the fever.

Dr. Duffey asked if there had been eliminated the possibility of the rash being due to drugs administered during the course of the disease. He had himself seen four cases of profuse miliary eruption following the administration of antipyrin. So, too, an erythematous eruption similar to scarlet

fever followed the administration of quinine, while scarlatinal eruption followed the administration of antipyrin, salicylic acid, and other drugs. Rashes occurred in fevers attended with serious blood-changes, and disappeared without any marked effect on the patient.

Dr. Pollock pointed out as remarkable that while most writers observed that the rash occurred in the first week or early stage of the fever, in a case of his the rash did not appear until the third week, although the rose spots had been out for a fortnight before. The pulse was never very high, but on the night of the 18th it suddenly rose to 108, and the rash was then noticed coming out over the back, chest and abdomen. Next day there was a sudden collapse—the temperature fell to 96°, and the pulse was low and very weak. On the following day Dr. Moore saw the patient, and on the day after the rash came out over the extremities. In reference to the medicines administered, he had given two grains of quinine, but, as it made the patient deaf, he stopped, and no more was given until after the erythematous rash disappeared. No antipyrin had been given.

Dr. Walter Smith said there were drug rashes and food rashes; and the explanation given by Dr. Duffey applied to many cases. Most rashes belonged to the erythematous class, and were due to a transitory disturbance of the vascular system of the skin, liable to arise in four different ways: First, direct action on the central nervous system by drugs; secondly, reflex irritation from the intestinal tube, produced by articles of diet; thirdly, direct dilatation of the vessels of the skin caused by such drugs as nitrite of amyl, nitro-glycerine, and alcohol; and, fourthly, the diffuse transudation of irritating drugs through the skin, as the essential oils of copaiba and cubebs, etc.

Dr. John William Moore replied that in Case No. 1, no medicine had been administered for some days, and the only possible cause of the efflorescence was the extreme rise of temperature, followed by sweating. It was not true erythema, but an efflorescence on the skin. In Case No. 2, he understood that the patient had been getting morphine to produce sleep, but only in small quantities; and that drug could scarcely have had anything to do with the development of the miliary eruption. In Dr. Pollock's case, quinine in only two-grain doses had been given several days before the rash appeared, but it disagreed, and was stopped.—*British Med. Journal*, Dec. 1, 1888.

Disinfection of the Air-Passages with Myrthol.

The Vienna correspondent of the *New Orleans Med. and Surg. Journal*, Dec., 1888, says that hitherto inhalations of turpentine in the respiration mask of Curschmann have been used for disinfecting the air-passages, or for combating putrid processes. Aside from the frequent disagreeable after-effects which were produced by this medication, the results also were very little favorable. In spite of the inhalations a patient affected with putrid bronchitis used to infect a whole ward in the hospital. Dr. Eichherst has recommended a medicament which, taken by the mouth, met all these inconveniences, and moreover favorably influenced the appetite and the general condition of the patient. This drug, myrthol, has a rapid and sure effect. It is that part of the myrtle-oil which boils at from 160° to 170° C. (320° to 338° F.), and which represents a clear fluid of an aromatic odor. It had formerly been recommended as a deodorant in bronchial catarrh. According to the present recommendation it is the best medicament for rapidly and surely combating the putrescence, and for removing the bad odor of the breath and the secretions.

When a gelatine capsule containing two and one-half minims of myrthol is taken the breath distinctly smells of myrthol for an hour, and this odor can also be perceived for twenty-four and even forty-eight hours after the administration. In putrid processes much larger doses are required; in most cases two capsules are administered at intervals of two hours. There is no disgust against the drug on the part of the patients.

Though myrthol proves very effectual in combating the putrid process and the bad odor connected therewith it is quite ineffectual for preventing an infection with tubercle bacilli, as tuberculosis developed even when myrthol was in use.

New York Academy of Medicine.

At the meeting of the Academy January 3, 1889, the annual reports of officers and committees were read. The total amount of money in the permanent fund is $120,776.85. The library has received during the year 1888 2,600 volumes, 3,235 pamphlets, 17,452 medical journals. Four thousand dollars was granted to the library for expenses during the current year. The number of members has been increased by 55.

NEWS.

—Dr. Horace Jayne will succeed Prof. E. Otis Kendall as Dean of the College Faculty of the University of Pennsylvania.

—Dr. C. N. Campbell, of Poughkeepsie, N. Y., died December 20. He was graduated from the Medical Department of the New York University in 1848, and was President of the Poughkeepsie Civil Service Board.

—Press dispatches indicate that small-pox exists in widely separated portions of this country. It is reported to be spreading in Albany, N. Y., and the inmates of Auburn State Prison are to be vaccinated. It is also increasing in New Washington, Ohio, to such an extent that business has been interfered with and trains are not allowed to stop. A few cases are reported from Newport, Kentucky.

—The Mills Training School for Male Nurses, in New York, was opened December 19. There were 110 applicants, of whom 22 were admitted to the school. The *Doctor* says: "The old Reign of Terror in many of our hospitals is drawing to a close. The Warden of Bellevue Hospital began discharging the orderlies in the wards for male patients the other day, and filling their places with the students just admitted to the new Mills school for training male nurses. Now the male patients will probably be as skillfully nursed as the female patients have been for some time."

—The New York *Medical Record*, January 5, 1889, says that the statistics of the New York State Board of Charities for the year ending October 1, 1888, show only a little increase in the number of the dependent classes other than the insane, and in the expenditures during the year as compared with last year. The whole number of insane in the institutions of the State on October 1, 1888, was 14,772, as against 14,062 on October 1, 1887, an increase of 710. This is the greatest increase in any year in the history of the State. All of the asylums are full, and many are greatly overcrowded.

DOUBTFUL CUSTOMER.—"Are these 'ere specs genuine crystal?" Street-stand merchant: "Chenooine? Of you don't mention it, I tell you someding. My bruder Isidore has bought dot Crystal Palace in England and is cutting him up into spectacles—dot makes dem so cheap. One dollar an' a halluf a pair!"—*Puck.*

HUMOR.

A MATCH between two dentists in their art would probably result in a draw.—*Boston Courier.*

WANTED THE FREE LIST EXTENDED.—Big Brother College-Graduate—"Are you in favor of wool being free of all duty?" Undergraduate (with conditions)—"Yes, sheepskins too."—*New Haven News.*

MISS KEANE (to handsome young physician)—"Oh, doctor, how do you do? You look killing this evening!" Young Physician (quietly)—"Thank you, but I'm not; I'm off duty, don't you know."—*Drake's Magazine.*

SOMEONE who has given attention to the subject says that anodynes are laborious in their operation. The discovery lacks the merit of originality, however. It has long been known that anodynes are pains-taking.—*Binghamton Leader.*

THE OTHER WAY ABOUT.—Irate passenger (as train is moving off)—Why the —— didn't you put my baggage in as I told you, you old ——? Porter—Eh, man! yer baggage es na sic a fule as yersel'. Ye-re i' the wrong train.—*London Punch.*

"HOW MUCH WILL A NEW SET of teeth cost?" "Fifty dollars, madam." "Oh, that is much too dear!" "But, madam, think: you will be able to eat with them." "Yes, but if I pay so much as that I will have nothing to eat."—*Fliegende Blätter.*

IT IS SAID that "a Dakota girl ate twenty ears of green corn for supper and then went to a party and danced all night." We should think she would. Eight ears of corn are enough to make some people dance all night—and howl, too.—*Norristown Herald.*

JOHNNY—"Pa, this paper says that Mr. Smith died intestate. What does that mean?" Pa—"It means, my son, that—er, that Mr. Smith had something the matter with his intestines—some sort of inflammation of the bowels, probably."—*Boston Transcript.*

A LONG TERM.—Irish guide to American tourist—"And there is no King nor Quane nayther in America, they're tellin' me, sur?" Indifferent Tourist—"No; we've a President there." "And how long have you been havin' a President, moight I ax, sur?" I. T.—"Oh, something over a hundred years!" Irishman, stopping, paralyzed with astonishment—"Howly saints! And do they live that long beyant there?"